Revista da Escola de Enfermagem da USP
ISSN: 0080-6234
reeusp@usp.br
Universidade de São Paulo
Brasil

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Identificação dos pilares da educação na disciplina integralidade no cuidado à saúde
Revista da Escola de Enfermagem da USP, vol. 46, núm. 4, agosto, 2012, pp. 985-993
Universidade de São Paulo
São Paulo, Brasil

The identification of the pillars of education in the class *comprehensiveness in healthcare*

IDENTIFICAÇÃO DOS PILARES DA EDUCAÇÃO NA DISCIPLINA INTEGRALIDADE NO CUIDADO À SAÚDE

IDENTIFICACIÓN DE LOS PILARES DE LA EDUCACIÓN EN LA DISCIPLINA *INTEGRALIDAD EN EL CUIDADO DE LA SALUD*

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ABSTRACT

The objective of the present study was to verify, based on the analysis of student portfolio narratives, if the four pillars of education were approached in the class "Comprehensiveness in health care", part of the integrated curriculum of the Baccalaureate in Nursing Program of the University of São Paulo at Ribeirão Preto College of Nursing. A qualitative, documental study was performed using 46 portfolios constructed during the classes. Data collection was performed using an assessment tool that contained items addressing cognitive and affective dimensions. The data were submitted to thematic categorical analysis using the pillars of education as predefined categories. The results show that the pillars of education were, apparently, included in the class. Despite the present study findings, no evidence was found that the expected competencies were actually discussed among students and faculty, according to the records regarding the evaluations of each pedagogical cycle of the studied class.

DESCRIPTORS

Education, nursing
Education, higher
Students, nursing
Curriculum
Comprehensive Health Care

RESUMO

O presente estudo objetivou verificar, a partir da análise de narrativas de portfólios de estudantes, se os quatro pilares da educação foram contemplados na disciplina "integralidade no cuidado à saúde" do currículo integrado do curso de Bacharelado em Enfermagem da Escola de Enfermagem de Ribeirão Preto (USP). Foi realizada pesquisa qualitativa, do tipo documental, de 46 portfólios construídos na disciplina. Para a coleta dos dados, foi utilizado um roteiro de avaliação contendo itens que contemplaram as dimensões cognitivas e afetivas. Os dados foram submetidos à análise categorial temática utilizando os pilares da educação como categorias predefinidas. Os resultados indicam que os pilares da educação parecem ter sido contemplados na disciplina. Apesar dos achados deste estudo, não houve indícios de que as competências esperadas foram discutidas entre alunos e docentes, nos registros referentes aos momentos de avaliação de cada ciclo pedagógico da disciplina estudada.

DESCRITORES

Educação em enfermagem
Educação superior
Estudantes de enfermagem
Currículo
Assistência Integral à Saúde

RESUMEN

El estudio objetivó verificar si los cuatro pilares de la educación se contemplaron en la disciplina "integralidad en el cuidado de la salud" del currículo integrado del curso de Bachillerato en Enfermería de la Escuela de Enfermería de Ribeirão Preto (USP), a partir de análisis de narraciones de portfolios de los estudiantes. Investigación cualitativa, documental, de 46 portfolios escritos en la disciplina. Para recolección de datos se utilizó una rutina evaluatoria que incluía ítems que contemplaran las dimensiones cognitivas y afectivas. Los datos fueron sometidos a análisis categorial temático, utilizando los pilares educativos como categorías predefinidas. Los resultados expresaron que los pilares de la educación parecen haber sido contemplados en esta disciplina. A pesar de los hallazgos del estudio, no hubieron indicios de que las competencias esperadas fueran discutidas entre alumnos y docente en los registros referidos a los momentos de evaluación de cada ciclo pedagógico de la disciplina estudiada.

DESCRIPTORES

Educación en enfermería
Educación superior
Estudiantes de enfermería
Curriculum
Atención Integral de Salud

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Received: 01/18/2010
Approved: 02/16/2012

INTRODUCTION

Higher education institutions (HEI), especially in health courses, have attempted to adopt flexibility, interdisciplinarity, contextualization, unicity of the relation between theory and practice and respect for ethical, esthetic and political values as part of their curricular proposals. These aspects are considered essential in the education of competent professionals to deal with the challenges of the 21st century. Therefore, students are expected to be prepared to deal with the complexity of the human being, the environment they live in and to make feasible resources that permit the construction of critical awareness about the context they are inserted in themselves. In this perspective, the intention of teaching is to privilege active, critical-reflexive approaches that permit competency building, covering political, ethical and technical actions, valuing students as comprehensive beings[1-2].

The challenge for education is to incorporate teaching proposals that that are inserted in the complexity paradigm, which discusses the reality of globalization and absorbs the construction of future professionals' subjectivity. Hence, there seems to be a consensus about the need to address values and skills in students with a view to lifetime *learning*, instead of learning in school only. Therefore, pedagogical strategies need to be defined that articulate knowledge with a view to developing the four pillars of education[3]: *learning to get to know or to learn*, acquiring the instruments or competency to understand; *learning to do* to be able to act on the involving context; *learning to live* or to live together, in order to participate and cooperate with other people on all human activities; and *learning to be*, considered the holistic view of man, i.e. spirit and body, intelligence, sensitivity, esthetic sense, personal responsibility, spirituality.

Hence, there seems to be a consensus about the need to address values and skills in students with a view to lifetime learning, instead of learning in school only. Therefore, pedagogical strategies need to be defined that articulate knowledge with a view to developing the four pillars of education...

In view of the above, in 2005, a new curricular structure for the Nursing Bachelor Program was put in practice at the University of São Paulo at Ribeirão Preto College of Nursing (EERP/USP). The Political Pedagogical Project is based on the integrated curriculum and on the competency-based pedagogical framework. The methods used represent a combination of (dialogical) problemization and significant (critical-reflexive) learning elements.

The integrated curriculum has been defined as the *pedagogical plan and its corresponding institutional organization that dynamically articulates work and teaching, practice and theory, teaching and community* [4]. Thus, according to this author, the teaching process established in that way should be based on the sociocultural characteristics of the means it is developed in.

The competency-based curricular perspective demands that students be able to mobilize multiple resources (knowledge, skills and attitudes) to deal with different field of social and individual life (task accomplishment, interaction with others, management of daily situations, among others)[5-7]. In the dialogical approach, competency building implies the development of (cognitive, psychomotor and affective) skills or attributes that will be mobilized in students in different ways, with a view to accomplishing actions in specific situations, in order to reach certain results that are characteristic of their professional practice[6-7].

In this context, constructive and *summative* assessments play a fundamental role. Students' performance is assessed through four instruments: activity simulating nursing practice, cognitive expression activity, student portfolio and teacher portfolio. The use of portfolios in education and professional training means represents an education, research and qualitative assessment strategy. It is a group of works and accumulated notes on activities that demonstrate the continuous acquisition of roles, knowledge, attitudes, understandings and personal and professional progress. It is both retrospective and prospective, used as an instrument to evidence the reflexive, collaborative and interpersonal nature of knowledge construction products and processes. It also permits a summarized idea of the competency that was built by providing a critical analysis of its contents[8-9].

As a continuous registration instrument of students' experiences, teachers analyze the portfolio in the middle and at the end of the subject taught, with a view to reflexively seeking means towards a constructive assessment of students' development. Student progress is analyzed, valuing all of their productions.

Looking at the trajectory of undergraduate teaching at EERP/USP consequently stimulates us to reflect on political-pedagogical work and the perspectives and challenges that need to be faced in the current contexts of education and health. In this study, we aim to verify, systematically and within a context, whether the four fillars of education were addressed in one of the subjects offered in the integrated curriculum model, based on the analysis of narratives in the students' portfolios.

METHOD

This research was accomplished in the subject *comprehensiveness in health care*, taught in the Nursing Bachelor Program at EERP/USP, created in the first semester of 2006 and offered in the second year of the program. The aims of the subject are to

develop knowledge, skills and attitudes for holistic care delivery to the individual and collective needs of adults and elderly people, in view of the biological, psychological and social dimensions present in the health-disease process; and to identify the health needs of health system users, formulate problems, elaborate, put in practice, register and assess the care plan.

It is based on the active method, a process that, besides concept definition, highlights criticism, discussion and knowledge exchange. The adopted problemization strategy aims for the integration of contents and the analysis of real situations through pedagogical cycles that comprise five moments: insertion in reality, preliminary synthesis, information search, new synthesis and assessment.

The practicum areas for this subject as Primary Health Care Units (PHCU) in the Western District of Ribeirão Preto (SP), the teaching area of the University of São Paulo. The students' task is to *collect data in order to get to know a given family's life history with a view to identifying its health needs*. Therefore, the teachers receive the help of PHCU nurses who use these services, who represent different phases of the lifecycle. Students, in turn, play their role through home visits and records, in their portfolios, about aspects related to the moments of the pedagogical cycle. Thus, they are oriented to write down what they observe during visits, knowledge gained and reflections about their feelings and personal growth in their interactions with the families, colleagues, faculty and PHCU professionals.

The methodological approach used in this study was qualitative research, indirectly accomplished through a documentary study[10]. Retrospective primary writings were used, i.e. the records written in printed portfolios elaborated by students who took the subject *comprehensiveness in health care* during the first school semester of 2006.

Out of 94 students enrolled for this subject, 76 signed the Informed Consent Term, agreeing with the use of their portfolios as analysis documents for research purposes, after the teachers' assessment.

At the end of the subject, the teachers received a letter, explaining about the study aims, and were asked to transfer these documents. In the end, access was obtained to 46 portfolios.

For the sake of data collection, the portfolios were identified numerically (P1, P2...) and an assessment script was used, with items that addressed the students' cognitive and affective dimensions. Records were compiled for the five moments in the pedagogical cycle, experienced during home visits, interactions at the health services and in the classroom.

Data were submitted to thematic category analysis, applicable to direct and simple discourse, and which works by dismembering the text into categories according to analogical regrouping[11]. In this study, the four pillars of education were used as predefined categories, as they constitute the guiding axis of the teaching proposal, based on the integrated curriculum and on the competency-based pedagogical framework that incorporates knowledge (*learning to get to know or to learn*) and skills (*learning to do*) into personal and social attitudes (*learning to live together* and *learning to be*).

The research project was analyzed and approval was obtained from the Institutional Review Board at EERP/USP, under protocol No 0648/2006.

RESULTS

The theoretical division of teaching based on the four-pillar model of knowledge[4] served as the axis for this study. Thus, the category related to the pillar *learning to get to know or to learn*, whose competence is to incorporate knowledge, was verified based on the records that synthesized the readings (internalization of knowledge) and dismembering of the description about the articulation between theory and practice. The category *learning to do*, which joins the competence of incorporating skills, was observed based on the analysis of the productions that resulted from theoretical-practical activities, developed critically and conscientiously (overcoming of intuitive and naïve understanding about the activity). The results related to the pillar *learning to live together and learning to be*, as they require similar abilities, were grouped in one single category (*learning to live together and learning to be*). Therefore, communication, interpersonal relationship, empathy and welcoming skills were observed, which refer to the competence of incorporating social attitudes (*learning to live together*) and facilities and/or difficulties to express their feelings towards the family they visited, the service team, colleagues, teachers and themselves, with regard to incorporating personal attitudes (*learning to be*).

Learning to get to know or to learn

This category is defined as the awakening of the pleasure of getting to know, understanding, discovering, constructing and reconstructing knowledge.

When experiencing real situations during their first day of immersion in the teaching-learning context, they students observed a range of aspects from a certain excerpt of reality. They understood that, at the PHCU, with the team and patients, and during home visits, with the families, they would meet the people who would become the subjects of their practical activities.

> We went to know a neighborhood. Walking around the streets, we could observe that this region is simple. This first moment gave me great perspectives. The presence of

a PHCU would grant us more direct contact with the reality of nursing care. The visits and recognition of the neighborhoods and micro-areas were very interesting, allowing us to characterize the context and living conditions of the region that will be an important tool for our learning. (P3)

I found in general that the city is based on a rural structure, many surrounding gardens and plantations. There are many hills, ascents and descents. I liked the first contact. I would like to learn a lot. I would like us to be inserted in a more practical than theoretical activity. (P1)

Another fact that called my attention is the large number of overweight and obese people. This reveals that, besides the lack of physical exercise, the population is not eating adequately, sometimes due to a disadvantageous economic situation or because they do not know how to use the nutrients in foods. (P6)

The family's house is very simple, the notion of hygiene was precarious. At this house, there are seven people surviving on the retirement benefit of "R" and the salary of *M*. Four people in the family consume alcoholic beverage. (P10)

The students showed concern with the application of techniques and their interventions in the families they monitored, complaining about little theoretical support for this purpose.

In view of certain situations we meet in the families we want to intervene, but we get disappointed because we can't, we don't have the scientific bases for that. (P7)

I participated in a task force at the PHCU. The experience was very fruitful. Learning all techniques for care delivery or a procedure does not include this contact with the user. It's different when we check one another's vital signs at the laboratory and when we go into immersion (PHCU and home), we are confronted with true health needs. (P22)

I observed an auxiliary applying a dressing. Several times she brought her hand close to her face and that act concerned we, because she could also get contaminated, not to mention the fact that she didn't wash her hand between one dressing and another. (P9)

The visit was not fruitful, as the family could not answer most questions, which made data collection rather superficial. I also made a mistake because I didn't check the vital signs, didn't do the physical examination; but that's justified by the fact that this is the first visit. I didn't know for sure how to proceed, nor had I learned about vital signs and physical examination. (P16)

In the excerpts below, the students revealed the understanding that they are experiencing a moment of learning, for which they need to assume a more humble posture, and that they do not possess all knowledge. They also perceived that, when they position themselves as apprentices, they grant themselves the possibility of personal growth in the accomplishment of their tasks.

Today was the differential with other classes, it helped me understand what health need really is, essential for my understanding. I think that, now, I am able to advance in the identification of a client's health need. (P15)

I got frustrated and sad because I wasn't able to collect blood. But I don't feel discouraged, I'll try again. Errors also produce learning and I feel driven to try more and more. (P18)

One of the students tried to percuss or auscultate the kidney. At that moment a great discussion started in the group. The student tried to accomplish a semiotechnique, but has no safe foundations to judge the data found during the examination. Many students considered this attitude courageous. But one of the things I've learned and agree with is that, in case of doubt, don't do it. We should be responsible for our attitudes and for what we say. I've learned in some literature sources that we should take risk sometimes, but these risks should have a minimum underlying foundation. If our attitudes are impulse, we are at risk of losing the family's credibility. (P27)

I got scared by the number of details in the "bed bath" procedure. I perceived the need to review the concepts. I feel frustrated because I didn't do the practical activity on the same day. Perhaps it was important to seek information in literature in order to fix my knowledge on this topic and have further arguments for the next theoretical discussion and bed bath practice. (P46)

The students presented considerations on the need to intervene in the population they attended, reflecting on the possibilities to do this.

Mr. J leads a sedentary life, he's fat, smokes, likes fatty food. It will be important for us to make him aware of the health risk. (P8)

I like to visit that family. I feel that I have to help with hygiene, education, behavior, recreation issues. (P14)

We talked with the nurse at the PHCU about the possibility of working at a recovery home where there are cases of scabies. I find it interesting to study scabies. I think that we want to go to far by presenting intervention proposals. We have a lot to learn. (P40)

Learning to do

This category is defined as someone's awakening to the creativity and construction of work.

The students in this study understood that they are responsible for their attitudes and that they need caution and theoretical foundations to execute some procedures involving the people they monitored or will attend in their future professional activity.

When *I* talked about the need to go to the PHCU to change the dressing, apparently a simple dressing and, later, when she received orientation on how to take care of the lesion at home, I felt the need to learn about the *dressing* contents as, although I found the lesion simple, I was not able to orient her about the healing. (P27)

> We discussed about how to better systemize our data collection and the interview, so as to make it more objective and concise. We built a small script for interviews, to remember what should not be left out. (P21)

> You need to preserve independence, privacy and demonstrate respect for the patient. To deliver individual care, we should ask, for example, about his hygiene habits without ignoring his economic conditions. We cannot show feelings of disapproval towards his way of living. (P4)

It can be verified in the reports below that the students identified certain problem situations in the reality, which they were inserted in. They used educative actions and creativity when providing orientations in family care. They explained and debated contraception methods, oral hygiene, care in the control of chronic conditions like hypertension and diabetes and about the prevention of infectious-contagious diseases.

> The patient complained of discouragement when we talked about the need to walk. So, we invited her and went for a short walk together. We explained about the importance of associating medication, food and physical exercise for hypertension control. We count on her daughter's cooperation, who is helping us, controlling her mother's food and routine. (P5)

> We presented a theater play about scabies at a school together with the PHCU nurse. The presentation was nice and I felt that we managed to transmit the information. (P15)

> We took condoms to explain to the women in that family. We asked them to, one by one, put the condom on a glass bottle. After they did that, we explained how to put it on correctly, as mistakes were made. We also informed them about correct contraception use and clarified some doubts. (P12)

> As *A* experienced difficulties to take the contraceptive pill regularly, we made marks on her calendar to indicate the day the display ended. This measure was necessary, as the client cannot read and, hence, it would not be feasible to write it down on paper. We asked the client to show us and explain about the marks on the calendar and she managed to say it correctly. (P9)

> We delivered explanation folders on how to keep one's teeth healthy and oriented about tooth brushing, use of dental floss, harmful food for the teeth and the importance of keeping up oral hygiene. (P28)

Learning to be and learning to live together

This category is defined as the discovery of oneself as an individual (self-esteem, self-determination, critical thinking) and as a member of society.

The students perceived that the people they attend could pay attention to their attitudes, behaviors and postures.

> The visit today made her reflect on the nurse's true role in the daily reality of users and their companions. Madam *N* added details about the history of her daughter's disease and death. She told that, at the hospital, she observed nurses who liked their work, but that some work because they are obliged to and in a bad mood. For me, a bad mood can mean a lot, but also discourage the user. In summary, as nurses, we should always pay attention to our actions and also think well about the questions we'll ask, as one slip can break the bond, impairing the treatment. (P19)

> Two colleagues cried today. According to them, *W* was apparently testing them. That made me reflect on our appearance. Were we dressing adequately? Using adequate ornaments? Transmitting the notion of hygiene (clean, combed hair, clean nails and well taken care of)? Everything patients and families know about us (behaviors) is based on our appearance, there is no way they can know about our studies and habits. Are we able to cause good impressions? Sometimes I think that the number of earrings I use can injure me one day, is that possible? (P25)

The feelings of insecurity, or of feeling *confused*, or even not knowing how to intervene and be afraid of offending illustrate the concerns and feelings the students presented.

> I felt the need for organization at the home, greater attention to hygiene and clearning for the family's health, but I feel insecure about giving the orientation, afraid that the family might feel offended. (P2)

> I am getting confused during the visits. There are many controversies in what the family members report. (P12)

> I like to visit that family. I feel that I need to help with hygiene, education, behavior, recreation issues. I feel that *B* still does not trust us. (P14)

In the excerpts below, the students acknowledged their perceptions of themselves and the context they were inserted in.

> We visited the vaccination room. We observed and talked to the mothers. I observed that I feel less timid when observing people, which is important for my professional accomplishment. (P25)

> The visits are tiresome and demand a lot of our attention. Nevertheless, they have been very productive with regard to care for *C*, not only physical but also psychological care. (P42)

The students identified the importance of the presence and relationship with teachers, colleages and other professionals.

> I feel that we managed to reach the expected goal of the subject. The teachers played an important role in that evolution. (P10)

> Even if personal disagreements exist, I believe the way we see one another will change. By the way, group contact obliges us to forgive many things. (P22)

> Being able to spend time in the work environment of a PHCU made be feel satisfied and joyful about learning to observe and exchange with other professionals. (16)

DISCUSSION

Learning can be understood as an act of knowledge about reality, about the situation the student experiences, which gaims meaning when it derives from the critical approach to this reality. In this research, as for the category *learning to know or to learn*, in the practice scenario, the students acknowledged characteristics of people and their probable common history, and also perceived peculiarities in the surrounding context. They appointed aspects the literature[12] considers positive (balance, satisfaction, organization and others) when they revealed that *the city rests on a rural structure, with many gardens and plantations*. Likewise, regarding negative aspects (disequilibrium, needs, difficulties, disorganization, and others), when they described that there are *overweight people* in that reality, that there exists a *lack of physical exercise* in those people, or that they live in an *unfavorable economic situation*. Hence, they managed to apprehend the wealk of first contacts with the families as part of their practice and that the primary perceptions based on appearances or common sense are tools that can help them to mobilize more thoughtful concerns and explanations.

Although they concluded that they were going through a phase of learning and personal growth, when doubts and uncertainties are expected, they showed the desire to intervene in the healthcare of the people they visited. They frequently presented complaints that they wanted to intervene, but that they did not know how to proceed. It is difficult for students to think of intervening or changing something in people, as they do not have a knowledge base yet on clients' social, economic, cultural and psychological aspects. They neither have the foundations needed to assess the needs of the people they monitor. Students and teachers are expected to have a clear image of the *what, when, how much and how they should learn*. They should observe reality from different related aspects (social, economic, cultural, psychological, political, ethical, administrative, among others) with a view to extracting the problems together, at this time of learning. From the perspective of teaching here-and-now (*problemization* method), in which the inductive method is central in learning, observation is considered the initial mark of intellectual inquiry, hypothesis formulation and a whole sequences of reasoning that leads to valid conclusions[13].

Teachers should clearly know about their observation (seeing, listening and feeling) function in this subject, and then be able to orient students before they execute the task (data collection). Students will not use the interview to apply instructions, orientations or perform technical procedures, but to clearly and comprehensively observe the reality they were confronted with. The interview comprises clear and subsequent steps. First, observation intervenes, followed by the formulation of hypotheses and, finally, their verification. One way to observe well is to formulate hypotheses while one observes and to check and ratify them during the interview itself, in function of subsequent and previous observations. Observing, thinking and imagining are part of a dialectic process, that is, in all human actions, one should think about what one is doing[14]. Students should learn to register and present what they observed, besides being made to think, reflect and obtain language instruments that are coherent with technical or scientific knowledge. Thus, educators are not only responsible for presenting the task, but for arousing, provoking, instigating and monitoring the students' interest in knowledge. They need to make efforts to show the meaning of the task as clearly as possible, so that student can value it and face the challenges in order to get to know it[15].

Therefore, both students and teachers need to understand that education goes beyond technical skills. That learning from the perspective of constructing, reconstructing, verifying, to be able to intervene and change, will allow students to act in complexing and challenging situations[16]. For this purpose, the goal is for educators to prepare and sustain the environment and teaching activities compatible with the job market, and to allow students to feel welcomed with a view to reorientation instead of judgement, reproof and exclusion[17-18].

In the subject *comprehensiveness in healthcare*, analyzed in this study, students were inserted in the job world, obtained experiences in the daily reality of health services and the community. They reflected on the problems of a given population and perceived that they need to exercise their knowledge incorporation competency. They perceived that they need to be judicious in learning to learn, be critical and inquisitive to act in individual and collective health care, as well as in health work organization and management[15-16]. Thus, the students who participated in this research seem to have achieved the expected competency for the pillar *learning to know or to learn*.

As observed, the students under analysis were concerned with doing already at the start of their learning, even before *learming to get to know or to learn*. In the evolution of the learning process, they demonstrated that they are moving from the passive position to that of an active subject (*learning to do*), indicating the ability to acknowledge that living with correct actions and mistakes is part of this process.

It should be reminded that it is part of teachers' functions to correct their students. This should be done, however, without disqualifying the student. Correction serves to redirect, to learn. When a student makes a mistake, learning can be analyzed, as a result of which educators can reconsider and redo their procedures. Everyone can make mistakes, even educators[15,17]. This posture in the

teaching staff is in accordance with the knowledge construction proposal, like in the care of the new curriculum at EERP/USP, which implies a pedagogical paradigm change.

The students' approach of the knowledge objects was perceptible in the fragments presented in the results section, when they describe that they felt the need to learn about the technical procedure to apply a dressing, that they got concerned with an auxiliary who could get contaminated and that they perceived differences between checking vital signs at the laboratory and at the primary healthcare unit. These records represent examples of these students' active bonding with the knowledge objects, which are related with a need, with an interest deriving from a subject's reality and from the social reality. At this moment, no direct knowledge transmission occurred to the students, but the flourishing of existing skills was made easier. People educate themselves when they are open to welcome what is new and use the knowledge and skills they have to intervene[19]. In this sense, learning is active, it results from a given subject's action on one or more objects or knowledge items.

What is believed and expected is that, in the construction of action plans for care delivery to each client, knowledge is put in practice according to each person's particular circumstances[20]. If, by chance, the group (students and teachers) needs to construct an academic *script* to guide the students' actions in practical activities, then one should actually be created. The use of a guiding *script* can be useful if students and teachers reach a consensus after discussing its positive and negative points, its true need and its meaning in learning. This group work serves as a model for team practice.

The student group under analysis seems to have overcome the intuitive and naïve understanding of theoretical-practical activities, which were developed critical and conscientiously. In this perspective, the competence of incorporating *learning to do* skills was addressed in the subject under analysis.

As for the category *learning to live and learning to be*, self-reflection led these students to acknowledgement, in a critical and conscientious view of their actions with regard to the context they were inserted in. They perceived that, when they participated in daily reality at health servicese and in the community, when they empathetically got involved with others and exercised their internal availability to deal with their difficulties and limits, they gained new knowledge and enhanced their personal and professional growth.

The students started to look at themselves as people and future professionals based on observations from relatives or perceptations that they are assessed in the context of their practice. They issued reflections that involved the assessment not only of know-how, or the execution of nursing practice (cognitive aspect), but also appointed aspects related to being and living with the other. For these aspects, the students' attitudes, subjective and objective skills are taken into account. In summary, the nursing students showed that they are learning how to relate with patients and themselves, knowing and unveiling the I, gaining awareness of their skills, i.e. constructing their professional socialization[13,16].

Besides the characteristics of the teaching environment, this learning process depends on students' internal and external factors, which can both facilitate and hamper this process and its outcomes[13]. Maturity, motivation, aptitudes, intelligence and previous experience are appointed as internal factors, including students' knowledge and skills. The physical-environmental and *psycho-socio-emotional* dynamic variables of the context-situation in which learning takes place constitute the so-called external factors. These cover, hence, the component elements of the teaching situation, which includes the content and method, the teacher's personality and performance, group members (students and teachers), interpersonal relations and the psychosocial climate of group functioning. Therefore, knowledge on these factors is fundamental, as students can feel and consider their participation, from the start of the activity, as an opportunity for personal growth and a challenge to their ability to cope with and overcome obstacles.

In knowledge construction, teachers, in turn, should understand the students and offer a welcoming and safe space and satisfactory time to allow them to express what they think, know and feel about the study problem and about themselves and the moment they experience[15,17,21]. The affective burden plays a fundamental role in the teaching-learning process. In addition, knowing the students' reality implies surveying their conceptions of the problem, without ignoring that part of their knowledge derives from the lay domain and that they have little experience in life. Therefore, teachers should heed their role of welcoming, feeding, sustaining and confronting the students, enabling them to construct and proceed on their route, with creativity and independence[17].

In this study, the students demonstrated concern with their relationships with colleagues, faculty and other professionals, in line with the interdisciplinarity perspective. The group is a space not only to learn how to think, but to observe, listen, relate one's own with other people's opinions, to admit that other people think differently[14-21]. Group work is one of the fundamental routes in students' education, as it enhances the development of social and ethical skills, which includes living with different opinions and values and respecting other people without casting aside mutual interaction[15]. If the necessary involvement and opening exist in the presentation of a situation or a problem, students can participate more spontaneous and authentically in the development of group activities, permitting the elaboration of the diagnosis for the situation under analysis, as well as the establishment of a care

plan[13,15]. Hence, when students share, they discuss what they have learned, plan contents, explore ways to do this with colleagues, with the faculty responsible for the group and service professionals. They get the opportunity to experience what interdisciplinary teamwork would be. Thus, the competences of incorporating personal and social attitudes of *learning to be* and *learning to live* seem to have been addressed in the subject under analysis.

CONCLUSION

In the integrated curriculum and competency-oriented teaching model adopted at EERP/USP, learning is process-based, that is, it ranges from individual activities to activities that are shared in practice contexts from the job world. The analysis of the narratives in the students' portfolios revealed that the expected competences for the subject *comprehensiveness in health care* were seemingly achieved. The students managed to relate their theoretical-practical learning with what they met in the real context, in the daily situations they experienced during their visits to families and services (primary health care units). This teaching-learning process occurred coherently with the critical-reflexive exercise of reconstructing the trainees' knowledge. In addition, a space for reflection became possible, which enhanced the construction of these students' professional socialization, preparing them for their future work in teams. The theoretical and practical activities in the subject under analysis took place in an integrated and multidisciplinary manner, as the students interacted mutually, with the teachers and service professionals. Consequently, the recommended interdisciplinarity in the National Educational Guidelines was complied with.

Despite the study findings, there were no indications that the expected competences were discussed among students and faculty in the evaluation records for each pedagogical cycle of the subject under analysis. Faculty, as facilitators of the teaching-learning process, should clearly realize that the competences to be achieved during the subject need to be constantly updated. This updating should be done together with the students as, in the integrated curriculum, assessment is constructive, i.e. the student's development is analyzed across the duration of the subject. Thus, in the students' portfolios, notes are expected about discussions they had among them and with the teachers about expected and achieved knowledge, skills and attitudes (competences).

REFERENCES

1. Brasil. Ministério da Saúde. Relatório Geral do 1º Fórum Nacional do PROFAE. Construindo uma Política Pública de Formação Profissional em Saúde; 2002 dez. 9-11; Brasília, DF [Internet]. Brasília; 2003 [citado 2009 nov. 22]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/profae/forum_parte1.pdf

2. Clapis MJ, Nogueira MS, Mello DF, Corrêa AK, Souza MCBM, Mendes MMR. O ensino de graduação na Escola de Enfermagem de Ribeirão Preto da Universidade de São Paulo ao longo dos seus 50 anos (1953-2003). Rev Latino Am Enferm. 2004;12(1):7-13.

3. Delor's J, organizador. Educação: um tesouro a descobrir. São Paulo: Cortez; 2001.

4. Davini MC. Do processo de aprender ao de ensinar. In: Brasil. Ministério da Saúde, Coordenação Geral de Desenvolvimento de Recursos Humanos para o SUS. Capacitação pedagógica para instrutor/supervisor - área da saúde. Brasília; 1994. p. 27-58.

5. Perrenoud P. Construir as competências desde a escola. Porto Alegre: Artmed; 1999.

6. Lima VV. Competência: distintas abordagens e implicações na formação de profissionais de saúde. Interface Comun Saúde Educ. 2005;9(17):369-79.

7. Leonello VM, Oliveira MAC. Construindo competências para ação educativa da enfermeira na atenção básica. Rev Esc Enferm USP. 2007;41(n.esp):847-52.

8. McMullan M, Endacott R, Gray MA, Jasper M, Miller CML, Scholes J, et al. Portfolios and assessment of competence: a review of the literature. J Adv Nurs. 2003;41(3):283-94.

9. Tanji S, Silva CMSLMD. As potencialidades e fragilidades do portfólio reflexivo na visão dos estudantes de enfermagem. Rev Enferm UERJ. 2008;16(3):392-8.

10. Lakatos EM, Marconi MA. Fundamentos de metodologia científica. São Paulo: Atlas; 2001.

11. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2004.

12. Berbel NAN. Metodologia da problematização: experiência com questões de ensino superior. Londrina: Ed. UEL; 1998.

13. Moscovici F. Desenvolvimento interpessoal: treinamento em grupo. Rio de Janeiro: José Olympio; 1997.

14. Bleger J. Temas de psicologia: entrevista e grupos. São Paulo: Martins Fontes; 1998.

15. Vasconcellos CS. Metodologia dialética em sala de aula. Rev Educ AEC. 1995;21(83):28-55.

16. Silva RF, Sá-Chaves I. Formação reflexiva: representações dos professores acerca do uso de portfólio reflexivo na formação de médicos e enfermeiros. Interface Comun Saúde Educ. 2008;12(27):721-34.

17. Luckesi CC. Avaliação da aprendizagem na escola: reelaborando conceitos e recriando a prática. Salvador: Malabares; 2005.

18. Ito EE, Peres AM, Takahashi RT, Leite MMJ. O ensino de enfermagem e as diretrizes curriculares nacionais: utopia x realidade. Rev Esc Enferm USP. 2006;40(4):570-5.

19. Chirelli MQ, Argerton APR, Rodriguez AG. O sentido da aprendizagem reflexiva na formação do enfermeiro: a construção da integralidade em saúde. In: Pinheiro R, Mattos RA, organizadores. Ateliê do cuidado: saberes e práticas no cotidiano das instituições de saúde. Rio de Janeiro: UERJ/IMS/ABRASCO; 2008. p. 309-29.

20. Reibnitz KS, Prado ML. Inovação e educação em enfermagem. Florianópolis: Cidade Futura; 2006.

21. Scherer ZAP, Scherer EA, Carvalho AMP. Grupoterapia com estudantes de enfermagem durante a transição teórico-prática. Rev Latino Am Enferm. 2007;15(2):214-23.

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