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Research Article

Conceptions about clinical practice in medical education: analysis of a course derived from the *Mais Médicos Program*

Concepções sobre clínica na formação médica: análise de um curso derivado do programa Mais Médicos

Concepciones sobre la clínica en la educación médica: análisis de un curso derivado del Programa Más Médicos

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Abstract

Introduction: After the institution of National Curriculum Guidelines for Medicine undergraduate courses, it is expected that the extended clinical practice will predominate in medical training, that is, one that has as its central focus individuals and their particularities. **Objective:** Through this study, we sought to comprehend the conceptions about clinical practice in the minds of students and professor of an undergraduate course in Medicine at a federal university located in the south of the country. **Methods:** This is an exploratory and qualitative study approved by the Research Ethics Committee of a federal university, under the opinion No. 2.950.932, of October 9th, 2018. Data collection was based on interviews with medical professors (n=21) and academics focal groups (n=43) that, subsequently, were processed by Bardin's content analysis. **Results:** Aspects inherent to the extended clinical practice were brought up, mainly those regarding a good doctor-patient relationship, the need to develop communication skills, and the balance between the humanistic, ethical and technical components. However, some statements aligned to the traditional clinical practice have been noticed, mostly related to the practice focused on diagnosis and treatment. **Conclusions:** Through these results, it is possible to conclude that, despite the presence of the extended clinical practice in the medical degree, it has not yet been fully implemented.

Keywords: Education, medical; Clinical medicine; Clinical competence.

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Resumo

Introdução: Principalmente após a instituição das Diretrizes Curriculares Nacionais dos cursos de graduação em Medicina, espera-se que seja predominante na formação médica a clínica ampliada, ou seja, aquela que tem como foco central o sujeito e suas particularidades. **Objetivo:** Buscou-se compreender as concepções sobre clínica presentes no imaginário de estudantes e professores de um curso de graduação em Medicina de uma universidade federal localizada no Sul do país. **Métodos:** Trata-se de estudo de caráter exploratório e qualitativo aprovado pelo Comitê de Ética em Pesquisa de uma universidade federal, sob o Parecer nº 2.950.932, de 9 de outubro de 2018. A coleta de dados deu-se com base em entrevistas com docentes médicos (n=21) e grupos focais com acadêmicos (n=43) que, posteriormente, foram tratados pela análise de conteúdo de Bardin. **Resultados:** Aspectos inerentes à clínica ampliada foram levantados, sobretudo no que diz respeito ao estabelecimento de uma boa relação médico-paciente, à necessidade de desenvolver habilidades comunicativas e de haver um equilíbrio entre os componentes técnico, ético e humanístico. Contudo, alguns discursos característicos da clínica tradicional foram notados, principalmente relacionados à clínica focada no diagnóstico e tratamento de doenças. **Conclusões:** Com esses resultados é possível concluir que, apesar de a clínica ampliada estar presente no curso em questão, isso ainda não se efetivou completamente.

Palavras-chave: Educação médica; Medicina clínica; Competência clínica.

Resumen

Introducción: Después del establecimiento de las Directrices Curriculares Nacionales (DCN) de los cursos de Medicina en Brasil, se espera que la clínica tradicional deje de ser predominante en la formación médica para que se priorice la clínica ampliada, es decir, la que tiene como enfoque central la persona y sus particularidades. **Objetivo:** A través de este estudio se buscó comprender las concepciones sobre clínica presentes en la carrera de pregrado en medicina de una universidad federal ubicada en el sur del país. **Métodos:** Se trata de un estudio exploratorio y cualitativo aprobado por el Comité de Ética en Investigación de una universidad federal, bajo el número 2.950.932, del 9 de octubre de 2018. La recolección de datos se realizó a partir de entrevistas con profesores de medicina (n=21) y grupos focales con académicos (n=43), que posteriormente fueron tratados por el análisis de contenido de Bardin. **Resultados:** Se plantearon aspectos inherentes a la clínica ampliada, especialmente en lo que respecta al establecimiento de una buena relación médico-paciente, la necesidad de desarrollar habilidades comunicativas y el equilibrio entre los componentes técnico, ético y humanístico. Sin embargo, se notaron algunos discursos característicos de la clínica tradicional, principalmente relacionados con una clínica enfocada al diagnóstico y tratamiento de enfermedades. **Conclusiones:** A través de esos resultados es posible concluir que la clínica ampliada está presente en el curso en cuestión, aún no se ha implementado en su totalidad.

Palabras clave: Educación médica; Medicina clínica; Competencia clínica.

INTRODUCTION

Throughout the history of public health policies in Brazil, especially before the Sanitary Reform movement that began in the 1970s, the traditional clinical model (biomedical) was predominant, that is, the one that deals with unraveling and treating a disease, leaving sick individuals and their singularities in the background. However, from different movements that culminated with the creation of the Unified Health System (*Sistema Único de Saúde* – SUS), these practices began to be questioned and demands for which the traditional clinic is limited were noticed, especially those cases that require understanding individuals, going beyond what the technical-scientific methods provide.[1,2] The polysemic concept of integrality goes against the traditional clinic. It moves toward the expanded clinic, as it includes aspects such as the organization of health services in a horizontal manner, the elaboration of policies aimed at the health problems of the population and the health practice that considers the subjects and collectivities in a centralized and integral way, addressing not only the subjects' illnesses, but acting to expand care for the varied needs of the population served.[3-5]

In this sense, the expanded clinic proposes to centralize the focus of health practices on the subject instead of the disease. Therefore, health professionals must understand the health and illness processes of a subject based on an integral view of the context in which they are inserted, be it biological, social, economic, cultural, psychological, family or other. For this expanded understanding to become a reality,

professionals need to use resources such as qualified listening, teamwork, humanization of care, empathy, and attention to singularities.[6]

Internationally, people-centered medicine is discussed, the one in which the patients' perspective is included in the process. In this case, in addition to the doctor's view of the functioning of the human body and the illness, there is also the view of the persons assisted, with regard to their experience with the illness process, their expectations of how their case will be approached and how their life routine will be affected by this. Thus, individuals become the fundamental piece for the reestablishment of their own health, in a way that they take on a responsibility shared with the health professionals.[7,8]

SUS provides that care is carried out according to the characteristics of the expanded clinic and with the patient at the center of the actions, that is, a humanized, ethical, responsible, and comprehensive care of the subjects, addressing aspects of health promotion and recovery and disease prevention.[9,10]

In order to keep up with changes in health practices, medical education has also undergone transformations. For a long time, medical education was based on the biologicist model, with the fragmentation of knowledge and the dissociation between theory and practice. However, for a few years now, Brazilian medical education has been reassessed and questioned. In this sense, the Ministry of Education instituted the National Curriculum Guidelines (*Diretrizes Curriculares Nacionais* – DCN) for undergraduate courses in Medicine in 2001 and reformulated them in 2014. Among numerous objectives, they predict that graduates will be able to work in the most different areas of health care along the lines of the expanded clinic, seeking to modify medical education.[10-12]

Therefore, the objective of this work was to understand the conceptions about clinic present in the imagination of medical students and professors of the graduation course in Medicine of a federal university located in the South of the country.

METHODS

This is a qualitative, exploratory research that was carried out in a federal educational institution located in a municipality in the countryside of the Southern Region of Brazil. The Medicine course at that university began its academic activities in 2015, as a result of the creation of the More Doctors Program (*Programa Mais Médicos* –PMM) by the Federal Government, whose one of its objectives is to increase the number of vacancies for the training of doctors in Brazil, in order to reduce the shortage of these professionals in SUS. In addition, the pedagogical proposal of this course is based on the DCN of 2014, that is, it provides that newly graduated professionals are able to work in different parts of the Health Care Network (*Rede de Atenção à Saúde* – RAS), developing actions of promotion, prevention, health recovery and rehabilitation, in a humanistic, critical, reflective manner and based on ethical principles.[12-14]

Data collection took place between November 2018 and April 2019 through semi-structured interviews with medical professors (n=21) and focus groups with students from different periods of the course (n=43). During the data collection period, there were 160 students enrolled and 52 professors working in the course, approximately half of them doctors. All medical students and professors were invited to participate in the study, and the sample was defined by convenience based on acceptance to participate. Subsequently, the audio-recorded speeches, derived from the interviews and focus groups, were transcribed, coded, categorized, and analyzed according to Bardin's method,[15] which uses the thematic content analysis technique in order to obtain a description of the content of the messages, with subsequent attribution of

meanings related to the speeches. The analysis categories were “extended clinic” and “traditional clinic”, which will be presented and discussed in the next item, with support from the relevant scientific literature.

This research was approved by the Research Ethics Committee through Opinion No. 2.950.932, of October 9th, 2018.

RESULTS AND DISCUSSION

Characterization of study participants

Of the 43 students who participated in the focus groups, 11 (25.5%) were in the eighth period (class 01-C1) at the time of the focus group, 12 (27.9%) were in the fifth period (class 02-C2), nine (20.9%) the fourth period (class 03-C3), and 11 (25.5%) the second period (class 04-C4). Of the total, 32 were women (74.41%).

With regard to the 21 professors interviewed, 13 were men (61.9%), the majority having graduated ten years ago or more (61.9%), and all declared having completed medical residency or some type of specialization. In addition, the time in teaching, for the most part, was less than ten years (76.19%), but ranged between six months and 25 years. It is worth mentioning that, since the analyzed Medicine course was relatively new, the teaching time of these professors at the institution was also short, ranging from three months to three years.

Conceptions about clinical practice: faces and interfaces between the expanded clinic and the traditional clinic

After analyzing the transcribed material, aspects inherent to the expanded clinic and the traditional clinic were raised, hence the categories of analysis.

Both professors and students, when instigated to define the word clinic, explained, in their speeches, characteristics of the expanded clinic:

> “Clinical practice is the patient in general, the patient’s care in a comprehensive way” (D12).

> “It covers a very broad concept of what we are seeing. It means observing, communicating, intervening, knowing how to talk, knowing how to listen, knowing how to analyze the person as a whole, inserted in a context. And, from that, you know what to do with the person. For me, that’s what clinical practice is about, it’s unveiling the person through the context they are in, the information they transmit through listening. That’s it, it’s knowing how to listen, communicate, intervene, act” (S18-C1).

> “It is the look in relation to what the patient is presenting. So, looking at the patients’ illness, looking at patients in an integral way, not just the disease, but them as a whole, everything they are going through, and observing a way to help, to guide them where they should be referred to or how they should be treated” (S26-C3).

These statements show that the clinic, when expanded, places its centrality on meeting individuals and their demands, whether arising from diseases or not. The disease can (and will) be approached, but

not as the ultimate goal, as understanding individuals and their health and illness processes is much more valuable than looking for technical signs that value the disease as it appears in books and guidelines. For health professionals to be able to understand this process, it is necessary to develop some skills that have in fact been mentioned by the study participants, such as observation, communication, and the ability to develop a good doctor-patient relationship.[16,17]

In this sense, the participants also listed some elements that are necessary for the expanded clinic to be successfully carried out:

> "For me, what is essential in clinical practice is an attentive look. I guess it's about paying attention to all aspects of the patients, both what you can physically see and their speech, trying to investigate the context in which they live" (S04-C2).

> "Technical elements in the sense of knowledge, scientific basis. Elements of interpersonal skills, of an integral approach, integral understanding of the being, of the individual and understanding of their uniqueness and tools that you learn, both in diagnosis, semiology and throughout the training, applying this in the consultation" (D21).

> "What will be important is that, in addition to the technical knowledge for the service, you'll need epidemiological knowledge, the knowledge of the situation, the diagnosis of the reality of the region where you're working. Without forgetting empathy and all those attributes that we have already learned regarding the need to walk in another's shoes, to give each patient care according to their reality" (S33-C4).

The research participants recognized that technical knowledge contributes to providing good clinical care. In addition, they also revealed that broadening the look to non-purely biological aspects can directly influence the health and illness process, since for the various aspects of one's life to be addressed, it is necessary for health professionals to be clear in their communication and promote an empathetic approach to the reality of this individual, as was highlighted by the research participants.[6,17]

In order to carry out a good clinical practice, both students and professors praised the construction of an adequate doctor-patient relationship as a fundamental skill to be developed:

> "Another important issue in the doctor-patient relationship, which is paramount, is centering care on the patients' needs and not on what we think is important for them. It means providing care focused on what patients need, what they really need" (S04-C2).

> "I think it is based on it [the doctor-patient relationship] that we'll be able to provide good care for patients in terms of information and clarifying doubts about the diagnosis and after therapy, as well as to make sure that patients feel comfortable in this service. I think that the doctor-patient relationship is everything and it can be a great threshold, both benefiting the patient and often not. So, it's no use having theoretical knowledge if in practice we can't establish a good doctor-patient relationship" (D14).

The moment of care denotes a meeting between people (physician and subject) who are protagonists of health production, and, as in any other meeting, they need to establish a relationship. However, when seeking

help from a health professional, subjects will share important and personal information about their health and their life in general. In addition, it will be necessary to perform a physical examination, which can cause embarrassment to patients if a relationship of trust is not built. This good relationship depends mainly on soft skills, which involve bonding, empathy, clarity of communication and recognition that the subjects have autonomy to decide what their real needs are, what information they should share, and even aspects of their treatment.[18,19]

As demonstrated in the previous statements, the doctor-patient relationship can directly influence the quality of care, either because, by being placed at the center of clinical practice and feeling comfortable with the doctor, patients tend to share more information and adhere better to the treatment, or even because doctors, when able to interact satisfactorily with the patient, will feel more confident and satisfied with their work.[18-20]

Regarding empathy, some research participants identified it as a key element for the development of a good relationship between doctor and patient:

> "Even after the diagnosis, if you have a good doctor-patient relationship, the odds of that patient adhering to the treatment is also greater. They'll come back. It's no use just criticizing, you have to know how to understand, have empathy, consider their social, the environment they live in to be able to adapt the treatment to this patient because this will also influence the clinical response a lot. What are their conditions to be undergoing this treatment, from financial to cognitive issues? Can they read? Or not? If I don't know this patient, I'll simply focus on a laboratory test and a prescription, the chances of this patient actually improving are minimal. I have to try to get into his life a little bit. And if they trust the doctor, if there's a good understanding, they'll increasingly bring more information and thus improve therapeutic response" (D10).

> "I guess what cannot be lacking in practice is empathy, that's the first thing that comes to mind. Because I think we always have to put ourselves in the other's shoes, especially the patient's, think about what they're going through and all the difficulties to have the best treatment and the best possible diagnosis" (S28-C3).

Empathy can be defined as a psychological, behavioral and affective process in which an individual seeks to approach the reality of the other through imagination, in order to understand a given situation and act in the best way in relation to it. Some studies point to it as a virtue, and others as a skill that can be improved. In addition, it is known that the empathy that involves health professionals and patients is a decisive factor for establishing a good relationship, directly impacting the satisfaction of both and the greater chance of building a bond and success in the diagnostic and therapeutic process.[21-23]

Certain works also address what is called "cultural humility", that is, the ability to understand that individuals are part of diverse environments, whose characteristics are varied. Given this, it is up to the health professional to relate to these unique individuals in an empathetic and humble way, so that they can broaden their eyes to consider the reality of the subjects served and also know and value their real needs.[9,21,22,24]

Empathy and cultural humility are fundamental tools, as they contribute to the development of a relationship between doctor and patient based on respect, with mutual empowerment, and which tends to be more lasting.[25] The communicative skills that were widely commented throughout data collection are equally important:

> "I think that, when we look at everything we do in medicine, it's all based on communication. 'Cause it's not just when I talk to the patient, sometimes it's about when I do not talk, when

> I perform a physical exam, for example, it's when I try to listen to what their body is saying. So, everything is communication" (S20-C1).

> "I think it's no use being very good technically, making an excellent diagnosis, then prescribing the correct treatment, the best one. But, if the patient leaves your office with a bad impression, you didn't establish that relationship, they didn't understand the prescription, they didn't understand what they have, the diagnosis you made or how important it is for him to take the medicine correctly, they'll get your prescription, they will, sometimes, even throw it away and won't even buy the medicine you prescribed or won't even go to the pharmacy at the health center to get the medicine or, sometimes, they even get it, but when they get home they won't take it. So, all the other things are of no use if you don't have a good doctor-patient relationship" (D16).

It is clear in the statements that communicative skills, which are also permeated by techniques and theories, are as important as other skills previously mentioned in this article. Communication is the basis of clinical practice, as it is established from the moment the subject meets the doctor, whether verbal or not. Afterward, communication will be necessary to collect the patient's history, transmit information and resolve doubts, perform the physical examination, make therapeutic agreements and relate to family members or other health professionals.[26]

For the communicative ability to be considered expanded and humanized, it is necessary that it be based on ethical principles and that the health professional respects and preserves the rights of patients. In addition, doctors need to make themselves understood, using clear and objective language, and also understand that communication involves non-verbal languages, being available to listen and understand what is being said, knowing when to approach, touch, smile, express sadness, support and attention.[26]

Developing communicative skills involves numerous factors and may not be so simple, despite being valuable. That is why, in the Medicine course in question, fifth-semester students undergo a Regular Curricular Component (RCC) entitled "Information and communication in health", which aims to develop this competence, focusing on care centered on person. This is because the DCN recommend that newly graduated academics be trained to interact in an appropriate and humane way not only with patients, but also with other health professionals, managers, among others.[12,14]

It should also be considered that, in the expanded clinic, a balance between technique and the humanistic component is necessary:

> "You have empathy for the patient, for their problem, for the situations they're going through. Then, of course, equally important, there's the technical qualification issues, so you can practice the profession. So, to be up to date, to really try and study and keep studying to be able to offer the best technical knowledge to the patient" (D16).

> "I think clinical practice is about really seeing the patient as they are and also putting into practice the knowledge you acquired in college. It's when you see the patient and know at the same time what they're going through, what you're going to do to be able to help this patient, and you have that technical and humanitarian edge to really be able to solve the patient's problem, because that's why they went looking for you" (S27-C3).

For a long time — and probably until today —, clinical practice was governed by purely technical and biological components. That is, dead labor and soft-hard and hard skills were widely used, while competencies from the relational and social field, the soft ones, were in parentheses. However, it was noticed that this does not necessarily lead to health care. In Brazil, the National Humanization Policy (*Política Nacional de Humanização* – PNH) encourages health work in the field of relationships, encouraging greater autonomy and protagonism of subjects and expansion of knowledge, meeting the subjective and social areas.[24,27,28]

In the discourse of the research participants, it was possible to note this appreciation of humanized knowledge, without excluding technical knowledge. This occurs because the purpose of health work is the care of the person and the identification of common interests with the subject regarding the disease and its approach.[24,27] Thus, as proposed by Schraiber,[29] the technical, ethical, and relational dimensions of the medical act must be intertwined, so that they complement each other, thus allowing to establish a good relationship with patients and also to provide adequate diagnosis and therapeutic options.

In addition, this combination of technical and ethical knowledge, combined with relational technologies, can be a support to establish an adequate relationship with the subject and to encourage their autonomy, since, by sharing therapeutic options, exposing benefits, side effects and solving doubts, they become aware of their health issue and acquire confidence so that, together with the professional, they become responsible for restoring their health.[4,20,28]

As for the technical issue, participants highlighted the importance of semiological components, anamnesis, and physical examination for clinical practice:

> "I think the main elements are the anamnesis and physical examination, they would be something [of] that the doctor should have mastery, that regardless of whether you have a perfect environment to work, a technological office, resources, and exams, if you don't know how to explore this part of anamnesis, physical examination and to have a relationship with the patient, diagnostic methods won't cut it" (S19-C1).

> "So, in fact, diagnosis will always come from anamnesis and the physical examination, which is the clinical practice. With that in mind, we can even ask for complementary laboratories, imaging tests as well, but what will guide the diagnosis is really the anamnesis and the physical examination" (D09).

At first, it can be inferred that these tools make up the traditional clinical practice. However, anamnesis and physical examination are part of the technical-ethical-relationship dimension mentioned above and, therefore, are essential to allow professionals to broaden the perspective of patients. After all, a well-collected anamnesis is one in which the subjects become protagonists of their own story and doctors are just facilitators who use communicative skills to establish a relationship of trust with the subjects. Health professionals should not make these elements "disease identifiers", but rather make them more effective by considering all the dimensions of the subject, giving space to the patient's ideas and words and realizing how the disease experience occurs in that specific subject, not just looking for signs and symptoms described in guidelines.[9,30,31]

These techniques depend on soft skills, such as relational ones: welcoming, bonding, and communication. Therefore, as commented by research participants, when these strategies are little

used, the traditional clinical practice predominates, especially in ordering complementary tests — often unnecessary — and in excessive prescription.[27,30]

Another important aspect raised, regarding the expanded clinic, is that it is not a responsibility of the medical professional alone, but of the entire health team:

> "I think that our clinical training has to remove us from this bubble that exists within our profession, which is being a doctor, leading us to relate to other professionals, knowing the importance of other professionals" (S39-C4).

> "I think that this relationship should mainly include the responsibility of medical professionals to direct patients to other professionals who can help, who collaborate with the main objective, which is solving the case. So that there's not that consultation thing going, and the patient goes back and forth, more consultations, exams. The context involves the need for other professionals in the area, whether psychologists or social workers, who interact in some way to make life easier for that patient" (S36-C4).

In order to approach subjects and collectivities in an integral way, it is necessary that professionals are integrated. However, in addition to the care given to a subject by several professionals from different fields, in the practice of the expanded clinic it is necessary for these professionals to work collaboratively and communicatively, seeking to address and understand the various aspects that can influence the health and illness process of an individual.[23,32]

Despite all these references to the expanded clinical practice, some participants stated characteristic of the traditional clinical practice:

> "The word 'practice', in my opinion, refers to what's most important in medicine, the ability to analyze signs and symptoms or complaints" (D01).

> "Clinical practice can also be understood as 'the practices', that is, medical specialties" (D02).

> "I think that clinical practice would basically be the study of all diseases and the interaction that these diseases have with the individual" (S06-C1).

> "For example, generalist medicine, which is my specialty, I think it is an area that involves knowledge of anamnesis, physical examination, associated with complementary tests to define a treatment. I think that the practice is the combination of several factors that we put together to reach at a definitive diagnosis and adequate treatment" (D08).

These statements show that the clinical method centered on the diagnosis and treatment of the disease is still present, which, in search of greater success, was divided into numerous specialties, actually ending up expanding knowledge about specific illnesses and fragmenting the look at the individual.[10,16]

In this traditional clinical model, it is observed that the semiological components were also highlighted, but not with the aim of focusing on the subject attended, but with the aim of intervening in a disease, either in its diagnosis or in its treatment. When the health professionals' goal is only to cure an illness, care is

compromised and is not always resolving, as the subjects are unique and may not present the diseases as determined by the empirical-scientific method. Thus, it is necessary to seek to know and understand the various nuances that can influence the health-disease process, whether physical, social, psychological, economic or environmental.[7]

However, it is worth mentioning that only one academic presented a characteristic speech of the traditional clinical practice. All other statements came from professors and, considering that most of these professors graduated more than ten years ago, when medical education was even more based on the biologicist, individualist, and hospital-centered model, the traditional clinical practice nature of their statements is understandable. It was only after 2001, with the institution of the first DCN, that education focused on the expanded clinical practice began to intensify. Furthermore, this process is still ongoing, as it requires a new way of thinking and acting from health professionals, teachers, and academics.[33]

This finding becomes a problem for the analyzed reality: how to guarantee the training of competent doctors to work in the logic of the expanded clinical practice if a good part of the medical professors were taught in the traditional ways and tend to reproduce it in teaching practices? The answer to this question demands the development of other studies and the analysis of other questions that were not addressed in this research. However, when analyzing the speeches of the students who participated in this study, who represent a portion of the student body of the medical course examined, their inclination toward the expanded practice is clear, which evidences that there are other factors besides the presence of medical professors who teach and apply the extended clinical practice. The presence of the field of Collective Health in all phases is cited, with activities conducted by a group of teachers with multiprofessional training who work in the logic of interprofessionality. Through the Collective Health RCC, students are inserted in health services, especially in the scope of Primary Health Care, from the beginning of the course. This strategy expands the students' view and contributes to the development of skills and abilities aimed at the expanded practice.[14]

FINAL CONSIDERATIONS

From the content analysis of the speeches presented, it can be inferred that the expanded clinic is present in the graduation of the analyzed medical course, in the imaginary and in the practices of medical professors and students. This scenario is consistent with what the DCN of Medicine courses predict, after all, professors and students are aware of the centrality of the subject in the practice of the expanded clinic and the essential competences for this practice — such as communicative skills, empathy, establishing a good doctor-patient relationship, multidisciplinary practice, valuing the patient's word, a watchful eye. In addition, they recognize the benefits that this practice brings, resulting in greater effectiveness of health work.

The traditional practice, however, was noted in some arguments, even if less frequently. The focus that this type of clinic gives to the diagnosis and treatment of a disease appeared a lot, in addition to the fragmentation of medical work into specialties. This panorama shows that the changes from a traditional to an expanded clinical practice are in process and that, although the course in question is moving toward what the DCN predicts, this has not yet been fully implemented.

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TSMAC: Conceptualization, Data curation, Formal Analysis. CB: Writing – Review & Editing. GSF: Conceptualization, Writing – Review & Editing.

CONFLICT OF INTERESTS

Nothing to declare.

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