

Training, Teaching, and Research in Family and Community Medicine and Primary Health Care in Brazil: current situation, challenges, and perspectives

Formação, Ensino e Pesquisa na Medicina de Família e Comunidade e na Atenção Primária à Saúde no Brasil: situação atual, desafios e perspectivas

Formación, Docencia e Investigación en Medicina Familiar y Comunitaria y Atención Primaria de Salud en Brasil: situación actual, desafíos y perspectivas

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In the year that marks the 40 years of the Sociedade Brasileira de Medicina de Família e Comunidade (SBMFC) and the 45 years of Family and Community Medicine (FCM) as a specialty in Brazil, this article brings — through interviews — thoughts and perceptions about FCM residency programs and the participation of this specialty in undergraduate courses, research, and health management. These interviewees represent the past, present, and future of FCM and SBMFC¹. Their history merges with that of SBMFC and FCM in these 40/45 years, considering some of the positions held by these professionals in FCM and SBMFC in this period. Their relationship with FCM and SBMFC can be found in the Editorial of this commemorative edition. The interviews explore aspects related to the challenges, advances, and perspectives of FCM and SBMFC in the process of teaching qualification, of increasing the number of specialists, and of expanding research and management qualification in the field of FCM and primary health care (PHC).

¹References and a brief history of the authors can be found in the editorial.

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RBMFC: What do you think about the current situation of Family and Community Medicine Residency Programs (FCMRPs)?

Ricardo Donato Rodrigues: I do not have enough knowledge of all FCMRPs, but in my experience, I believe that the vast majority is of good quality, recognizing that it is always possible to improve. In this regard, I include the importance of preceptorship and FCM training in all aspects. One cannot neglect the family approach and the community approach alongside the person-centered clinical approach.

João Werner Falk: Overall, they are good, but there is a lot of contrast in the quality of programs and supervisors, as well as in the quantitative relationship between residents and supervisors, making it difficult to achieve the minimum required competency matrix that residents should have when concluding their FCMRP. We need more programs and more positions in the existing ones because the number of FCM specialists is still far from what the population needs.

Airton Tetelbom Stein: I think it still has a lot of differences — programs of excellent quality and others that need SBMFC support. We need a greater exchange between FCMRPs. After the COVID-19 pandemic, I suggest that this area should also receive support for a broader exchange. Visits by Family and Community Physicians (FCPs) from other countries to FCMRPs should be encouraged, in the same way that preceptors and residents should visit programs in other countries. The person-centered method and evidence-based health should be promoted and emphasized in the training of future FCPs.

Maria Inez Padula Anderson: Development policies of the last 15 years have led to an exponential quantitative growth in the number of programs in Brazil. This is very positive, and we should understand that. However, considering that we still have a low relative and absolute number of FCPs, including in preceptorship, we must recognize the need to progressively improve the current residency programs. Thus, based on the current situation, we should have a concrete direction regarding where we want to go, how to get there, and how long it will take, especially regarding structuring competencies — the essential ones — that must be developed in the two years of medical residency. In this case, more than “showing them **the different types of fish** during residency, in a fragmented view of care, **we need to teach them how to fish,**” and, to that end, the structuring competencies to be developed should be related to the systemic paradigm, the person-centered approach, the family approach, and the community approach. SBMFC has participated in this qualification effort, mainly in the training of preceptors, started 15 years ago across the country. But we need to move forward now, working on the minimum skills to be developed in FCMRPs — considering next the continuing professional development process as a medium- and long-term key strategy. We also need to act directly in training spaces for FCMRP preceptors. They are the ones who will spread these improvement actions.

Gustavo Gusso: I believe they are excessively heterogeneous, most of them focused on the Family Health Strategy (*Estratégia Saúde da Família* — ESF) and not specifically on FCM, that is, unable to teach such specificities (FCM vs. ESF vs. PHC).

Nulvio Lermen: I see a movement of historical expansion that has been greater in other times. I believe that, despite these advancements, we need a national policy to regulate medical training that can appropriately respond to the needs of medical provision, which directly affects FCM.

Thiago Trindade: We have achieved a significant expansion, but we still have very heterogeneous programs from a quality point of view. I emphasize the need to review our competency-based curriculum and to fully implement it in the programs. To keep improving preceptorship and the models, as well as the evaluation processes. Finally, we need to move toward the accreditation of these programs.

Daniel Knupp: After a few years of expansion in the number of positions, I believe we have reached a plateau. To move beyond this level, I think we will have to address the issue of idle positions, which is linked to the situation of FCM in general and how the training of specialists is regulated in the country.

Zeliete Zambon: We currently have many open positions, but we are far from having quality and minimum homogeneity. The competency curriculum needs to be revisited: 334 competencies are way too many for two years of residency, and we also have to work on feasible evaluation methods to achieve these competencies.

Ana Clara Arantes Gonçalves and Geferson Pelegrini for the Residents' Board: We noticed its expansion and presence in a large number of these residency programs, especially in smaller cities, contributing to the establishment of FCM in these locations. However, this same diversity, the lack of preceptors or focal supervisors, in addition to the low number of positions filled, make it very difficult to a more homogeneous assessment of these programs; so, we now see a significant heterogeneity in the training of family physicians in each residency program. In this sense, we still need to improve our evaluation methods, as well as demand the minimum quality criteria required for these programs and thus ensure better quality education.

Priscila Ferraz Bortolini for the Associação Brasileira de Ligas Acadêmicas de Saúde da Família (ALASF): FCMRPs have been strongly structured, but we still face some difficulties, such as the “shoulder-to-shoulder” preceptorship, due to the lack of qualified professionals for this role.

RBMFC: How do you think FCMRPs can contribute to improving FCM and quantitatively increasing the number of FCPs in Brazil?

Ricardo Donato Rodrigues: Residency is the most appropriate training model. Preceptorship is crucial for the training of residents — ideally, it should have two residents/preceptor; the working resident's introduction to FCM and adequate working conditions, with a more in-depth theoretical and theoretical-practical approach in all areas of activity of the specialty, should agree with active teaching-learning methodologies; and they should start participating in research/knowledge projects in the specialization field.

João Werner Falk: Preparing the preceptors with continuing education activities; SBMFC and state FCM associations promoting virtual or face-to-face events for residents and preceptors; increasing the participation of FCM in undergraduate medical courses by raising the number of FCM professors in medical schools. Keep holding test and curriculum entrance examinations for the Family and Community Medicine Specialist Title (*Título de Especialista em Medicina de Família e Comunidade* — TEMFC).

Airton Tetelbom Stein: The assessment of clinical skills should be more standardized; for example, by implementing an objective structured clinical examination (OSCE) and having simulation laboratories available for data collection training and the performance of physical examinations. Quaternary prevention training should be encouraged, and overdiagnosis avoided.

Maria Inez Padula Anderson: Given their characteristics, residency programs are the gold standard for specialist training. Thus, they are the most appropriate method to train FCPs, as well as improve the knowledge and practices of this specialty since they have the most favorable conditions for this endeavor, either through working scenarios or through the reflective teaching-learning process that they must develop. As for the quantitative increase, FCMRP inland expansion initiatives are strategic and promising, as they can have a snowball effect toward the strengthening of PHC in the municipalities and, at the same time, contribute to improving the number of positions.

Gustavo Gusso: Residency positions should be regulated and have a mandatory period.

Nulvio Lermen: FCMRPs are essential for the training of specialists in the area. Its strengthening should be a government priority, but its successful expansion depends on a national policy to regulate medical training, which has been needed for at least a decade.

Thiago Trindade: Residency remains the gold standard for FCP training, and all new physicians who wish to work in PHC should do this residency. Thus, having quality programs, which attract and train more FCPs for the system, guarantees the growth of the specialty and increases the offer of this specialist to SUS (Brazilian public health system). We still have a huge gap in this specialty — about at least 40 thousand professionals, if we consider only the current family health teams. Therefore, we have an urgent need to continue promptly training these specialists through FCMRPs.

Daniel Knupp: FCMRPs have always taken on the role of providing state-of-the-art training in this specialty. Certainly, this role should be maintained. However, there should be more cooperation and exchange between FCMRPs in order to improve FCM and fix specific deficits that may exist in some of these programs. We must ensure that any students who completed their FCMRP have developed the desirable skills of the specialty. In addition, a greater closeness between FCMRPs, undergraduate courses, and services is fundamental to encourage the training of more FCPs.

Zeliete Zambon: The first step should be qualifying FCMRPs.

Ana Clara Arantes Gonçalves and Geferson Pelegrini for the Residents' Board: Residency programs are the main ones responsible for improving the family physician practice. Without them, the specialty would suffer a great loss since it is during medical residency that the resident observes more experienced professionals and also builds their theoretical basis on the attributes of the specialty, relying on the supervision and evaluation strategies aimed at their constant improvement. This is not possible for those who work in PHC and are not in a residency program, with protected and longer-term visits. FCMRPs can increase the number of FCPs in Brazil by providing positions and occupying basic health units that do not have residents yet, combined with a quality preceptorship.

Priscila Ferraz Bortolini for ALASF: The program is essential for the scholar/resident to know the real role of FCPs and to develop competencies that undergraduate programs do not provide.

BMFC: What needs to be done to increase the number of FCM residencies and residents?

Ricardo Donato Rodrigues: 1) progressive increase in the number of positions offered (until reaching 40% of residency positions); 2) scholarship complementation, considering the reality of the labor market in this area; 3) adequate conditions in training units; 4) career perspective.

João Werner Falk: In addition to all that has been listed, we need to have: national budgetary policies for creating new programs; scholarship complementation for all FCM residents in the country; and the possibility of grants for preceptors. Find the locations that most need FCPs and create conditions for the establishment of new FCMRPs there.

Airton Tetelbom Stein: Contact the Ministry of Health and make national training programs in FCM feasible in all municipalities — promote the concept that “everyone should have access to a family doctor” and have campaigns to show society the importance of this notion, especially by valuing the PHC team and fostering clinical concepts, social determinants, and, increasingly, global health.

Maria Inez Padula Anderson: I believe it is essential to regulate the number/percentage of positions in residency programs for all specialties, as is the case in many countries, such as Canada, for example. This regulation is crucial for public authorities to act toward training professionals based on the health needs of the population and not on corporate and/or institutional interests, as is the current scenario in

Brazil. According to the World Health Organization, the percentage of FCPs in a country should be around 40 to 50%. In this regard, SBMFC has a relevant role, taking technical and political actions to establish policies aimed at achieving this percentage.

Gustavo Gusso: Regulating the positions and planning to make this residency mandatory for the practice of several specialties.

Nulvio Lermen: A national policy to regulate medical training focused on providing specialists for all country regions.

Thiago Trindade: Financial support from the three spheres of government to guarantee appealing scholarships/grants for residents and preceptors, helping attract and retain these residents and partially ensuring the quality of these programs. But the main turning point for the occupation depends on the regulation of the system, on making the specialty mandatory for the professional practice of PHC for future generations. In association, we need an expansion of the labor market and guarantee non-precarious employment, with good career plans and wages.

Daniel Knupp: In addition to the role of FCMRPs mentioned earlier, I believe we should advocate for substantial changes in the regulation of specialist training in the country. We must continue to actively defend mandatory medical residency for the practice of medicine, the regulation of the distribution of residency positions according to SUS needs, with at least 40% of positions for FCM, the elimination of prerequisites among specialties (direct access to all of them), and medical residency as the only way of training specialists.

Zeliete Zambon: At the moment, I think the solution is to improve the existing programs. Rather than increase the number of positions.

Ana Clara Arantes Gonçalves and Geferson Pelegrini for the Residents' Board: To increase the number of residencies, more FCPs need to migrate to places where this specialty is still scarce, or even to areas with no FCMRPs yet, but where there could be an academic relationship. First, however, the large number of idle FCM positions in current programs must be considered, and efforts should be directed toward filling these positions and enhancing these programs. Some efforts have been made to raise the number of residents, such as increasing the number of hours allocated to the specialty during undergraduate courses. Another factor that improves the number of residents is the benefit granted to those interested in doing the residency of other specialties after finishing their FCM residency, as well as providing complementation for scholarships, whose current value is extremely outdated for all medical specialties and demands the inhuman and unhealthy workload of 60 hours a week. The number of FCM residents may increase with the improvement of the existing programs. These quality programs will, indeed, train outstanding specialists capable of disseminating good practices wherever they are. These same specialists, when more engaged in academia, also raise the students' interest in the area and their involvement in PHC research. In this sense, monitoring the quality of programs and ensuring they have family physicians in preceptorship and coordination positions is crucial.

Priscila Ferraz Bortolini for ALASF: More FCPs teaching in undergraduate courses. Demystification of the specialty, showing that FCM is based on science and not a "mystical" specialty.

RBMFC: How important do you think it is to incorporate FCM in undergraduate courses?

Ricardo Donato Rodrigues: The inclusion of FCM in undergraduate courses is essential, starting at the first years of college, ideally in partnership with FCMRPs.

João Werner Falk: The inclusion of FCM in undergraduate courses is fundamental for students to know and value the specialty, in addition to keeping in mind the possibility of doing an FCM residency. It is important to have FCM academic associations in all undergraduate medical programs in the country.

Airton Tetelbom Stein: I think it is essential. A good undergraduate experience in FCM will make the former student a good physician, regardless of specialty. This part of their education allows them to know the importance of prevention and actions based on population indicators and not only on individual clinical care.

Maria Inez Padula Anderson: Without FCM in undergraduate courses, FCM departments, or an equivalent structure in medical schools, we do not have a concrete reference of what FCM is for medical students; we do not have a role model. No one wants what they do not know exists. In this scenario, we need public policies to mandatorily include FCM specialists and FCM departments/centers in undergraduate medical programs. Most of the time, initiatives to incorporate FCM concepts and practices are under the responsibility of the Preventive and/or Social Medicine departments, without FCM specialists, as if that were enough. Of course, the first is important, but it should not supersede the second. Also, they often indicate a professional practice separated from essential FCM clinical competencies, a situation counterproductive for the specialty, which, albeit differentiated, is eminently clinical. In addition, it is crucial to think and build PHC as a teaching-learning scenario, as is the case in university hospitals. These two parameters should be included in the evaluation instruments of medical schools.

Gustavo Gusso: I believe there has been progress when it comes to incorporating professors, but departments are still scarce. The biggest problem has been the segregation of subjects linked to primary care from clinical disciplines. In countries like Canada, 70% of undergraduate disciplines, such as propaedeutic, are taught by family physicians. Semantic confusion has become another issue: content focused on preventive medicine and health policies is now often called "PHC".

Nulvio Lermen: FCM should be the basis of training. The proposal of the conclusion of the medical program should be replaced by education grounded in a general structure that would then necessarily branch to specialized training, complementing the undergraduate course, thus showing that FCM is a specialty with its own specificities that needs to be understood and practiced according to a particular training provided by medical residency.

Thiago Trindade: It is essential to insert FCM into undergraduate courses since they introduce the specialty to the student and build the necessary skills for the practice of this general practitioner. This has a crucial impact, shaping the role of FCM professors so graduates can recognize the specialty.

Daniel Knupp: In undergraduate courses, FCM plays a key role in the scientific development and recognition of the specialty. However, it is also pivotal in qualifying medical training in general because the presence of FCM principles in education ensures that even graduates who will not work in FCM/PHC become better health professionals.

Zeliete Zambon: Incorporating FCM in undergraduate courses is very important. Without a role model, the student cannot actually choose FCM.

Ana Clara Arantes Gonçalves and Geferson Pelegrini for the Residents' Board: The inclusion of FCM in undergraduate courses is crucial since it is a medical specialty like any other and should therefore be known to doctors in training. In addition, knowledge of and respect for the specialty start when one understands what the family physician does. The notion that basic health units do not provide good medicine or even great challenges is still present in many contexts, although this is improving. Including the specialty in undergraduate courses shows that allowing students to come into contact and learn the

principles of the specialty also improves health care in this scenario, where most students will probably work after graduation.

Priscila Ferraz Bortolini for ALASF: It is imperative to insert FCM into undergraduate programs so that we have more FCPs in the future, as it is in undergraduate courses that we will ascertain what kind of professional we would like to be.

RBMFC: How do you rate the importance of inserting FCM into management?

Ricardo Donato Rodrigues: The inclusion of FCM in management is also fundamental. The complexity of ESF/PHC requires managers with this level of training and experience.

João Werner Falk: Many problems faced by FCPs and other PHC professionals result from managers with low managerial competence or who lack knowledge of the importance of PHC and, particularly, FCM. When FCPs hold management positions, they tend to achieve better results.

Airton Tetelbom Stein: The inclusion of FCM in management is also essential and should promote the knowledge of coordination as one of the attributes of FCP training.

Maria Inez Padula Anderson: Including FCM in health management at all levels — municipal, state, and federal — especially but not exclusively in PHC is critical. Given the lack of understanding of what qualified PHC is, we often see a “simplification” of management spaces at this system level. Experiences in the Ministry of Health, like the one with Claunara Mendonça, and in the city of Rio de Janeiro with Daniel Soranz, first as PHC Undersecretary and later as Health Secretary, exemplify the promising results of these initiatives, which impact the entire health system, be it in the management of units, primary care secretariats, or environments dedicated to PHC and other system levels. The fact that PHC should coordinate the health system explains, by itself, the advantages of having professionals who know and practice PHC in health management. We need to move toward having FCM in academic and research management as well.

Gustavo Gusso: As in undergraduate courses, FCM has advanced in management, but initiatives are still restricted to “ghettos” segregated from the broad system, which remains uncoordinated and does not differentiate primary from secondary care.

Nulvio Lermen: The general nature of FCM training and the principles described by McWhinney, especially the one that defines FCM as the resource manager for its population, give an advantage to professionals trained in this specialty, as they can work in the management of health services and the elaboration of public policies targeted at the health of the population. I think it is essential that more specialists in the field assume a leading role in public management and also in private care, with the purpose of shaping our health system, thus, ensuring the application of PHC attributes to the construction of the health system and resulting in better clinical appropriateness and higher cost-effectiveness for the system as a whole.

Thiago Trindade: FCPs have made a difference in management, given their ability to see a user-centered health system, as they actually know the needs of this user. Therefore, when they apply their training in community and collectivist aspects to management, they can advance the expansion and enhancement of the Brazilian PHC.

Daniel Knupp: The presence of FCM in management spaces at all levels — municipal, state, and federal — is very important for the strengthening of SUS, particularly for the improvement of PHC.

Zeliete Zambon: Without FCM in management, organizing the health system will become increasingly difficult, leading to less investment in PHC; greater investments in tertiary care, totally disconnected from PHC; and insufficient secondary care, creating a bottleneck in the health system, that is, we will never actually give people access to health.

Ana Clara Arantes Gonçalves and Geferson Pelegrini for the Residents' Board: FCM in management can bring the perspective of this specialty on the quality parameters of its work. Considering the large number of professionals working in basic health units without FCM qualification, FCPs need to show the differential of their work and why their work dynamics are often distinct from that of general practitioners who work in PHC but without specialization. This scenario makes it easier to justify or even encourage the more efficient creation of resources destined for primary care. Another important factor is to make management more receptive to teaching activities inherent in FCM, such as medical residency.

Priscila Ferraz Bortolini for ALASF: Few specialties can see health management in an integral way, like FCM.

RBMFC: How do you see the role and importance of master's and doctoral degrees in the development and qualification of FCM and PHC? How necessary is it for research development to be thought and carried out by FCPs?

Ricardo Donato Rodrigues: Master's and doctoral degrees in FCM/PHC are essential for teaching training and the production of specialized knowledge in this field. Research in the PHC scenario by FCPs and professionals working in the field is also imperative for the evaluation of existing technologies and the production and incorporation of new ones — light or industrially produced (hard) —, adjusted for the practice of the specialty.

João Werner Falk: Master's and doctoral degrees in FCM/PHC are important for the scientific development of PHC and for increasing the number of FCPs with the prerequisites necessary for application/enrollment in entrance examinations for teaching positions in medical schools, as well as other examinations or selection processes. Regarding research, we know that the development of an area of knowledge, such as PHC and the FCM specialty, is essential to the area itself and to the population. When FCPs plan and conduct research, bringing the views and experiences accumulated by their daily work, the results become even more relevant. In addition, this research bolsters their curriculum and provides greater opportunities in the labor market, including, for example, their admission as professors in medical schools and as preceptors in residencies.

Airton Tetelbom Stein: Medical training, regardless of the specialty, must be increasingly encouraged to create a more comprehensive academic education, and there is a growing need for professors with the skills to teach future FCPs. We see a great need for FCM research. Having indicators to evaluate the effectiveness of FCPs in their region is essential; for example, developing research in an area with sensitive outpatient care conditions is crucial to evaluate performance, as well as define strategies to improve the quality of life of patients treated in a certain geographic region.

Maria Inez Padula Anderson: In any specialty, master's and doctoral degrees are particularly important for academic education and integration. This is also true for FCM, especially for the elaboration of research and studies in the field of PHC and FCM itself. Most of the knowledge we use in PHC comes from other system levels and still retains a logic centered on positive epidemiology with a quantitative nature. Although we have much to learn from other system levels, we must identify, develop, and record experiences and learnings based on FCM and PHC concepts and their practical applicability. No one can do that for us. In this field, we need to claim methodologies that advance the field of qualitative research, especially when dealing with light technologies, which are very important to FCM and PHC and perhaps less so to other levels. We also need methodologies that take into account biopsychosocial and spiritual paradigms and the evaluation of the efficiency/effectiveness of diagnostic and therapeutic approaches that result from these concepts. We must establish better-designed health indicators and this paradigm. We still

work with end indicators and have few studies on process indicators, either of qualitative or quantitative nature. For instance, we are still attempting to find adequate or inadequate glycosylated hemoglobin results, but we have not identified the therapeutic processes involved in these results, which certainly go beyond the mere prescription of medications. In this scenario, we do not value the essence of FCM and PHC and remain guided by other specialties and system levels.

Gustavo Gusso: A master's degree focused on FCM, which does not yet exist in Brazil, would be important. I understand that research in and by PHC has made less progress as an area, but this situation is common even in European countries and can be evidenced by the low impact of scientific journals focused on PHC/FCM.

Nulvio Lermen: I think having master's and doctoral degrees in FCM/PHC is very important for incorporating the specialty into academia and ensuring we have more professors and researchers in the area. As a result, we will make it possible for FCM to become increasingly present in the medical training process. I believe a graduate policy at the master's and doctoral levels should be encouraged for our specialty; however, it should focus on professionals who want to work in academia, given the lack of FCPs with such training so that they can hold positions in universities. In this sense, considering the need for concentrating efforts on increasing the number of FCPs, I do not believe it is essential or desirable, at this moment, to have this master's and doctoral education for professionals who wish to remain exclusively in clinical practice. For them, a policy for continuous improvement and certification would be much more beneficial. Research on PHC is very important to strengthen the health system as a whole, both from a clinical point of view and for the organization of resources and improvement of the work process. Therefore, it should be essential for the decision-making process of system managers. In this regard, I think it should be fostered and funded by the health system as a management resource.

Thiago Trindade: Graduate research training is essential for the development of FCM as a knowledge area because research allows us to evaluate and enhance the foundations of the specialty in order to further improve the Brazilian PHC. We need to advance to have FCM master's programs. This is a deficiency of the area throughout Brazil. The essence of the FCP's perception, in the eyes of the individual, their family, and community, brings to PHC-centered research a significant and much more practical production of knowledge. Studying PHC epidemiology and problems prevalent at the community level makes a huge difference in the search for new evidence separate from those presented in studies conducted in other training scenarios. Research in Brazil and in the world is still very hospital-centered; thus, we need to advance the PHC production, with FCPs leading research groups and adding their perspectives.

Daniel Knupp: As in management, the presence of FCM in the research scenario is very important for strengthening SUS, particularly for the improvement of PHC.

Zeliete Zambon: We need to increase, systematize, and improve the research on PHC. In addition, being within medical training centers is a strategy for FCM. We also need research references with PHC outcomes and to stop importing hospital data or information from focal specialties.

Ana Clara Arantes Gonçalves and Geferson Pelegrini for the Residents' Board: Master's and doctoral degrees are tools that chiefly prepare the professional as to the scientific method, which is based on strict criteria and that we use to guide practices and make discoveries in health. In this regard, we ensure that professionals will know how to use good evidence to benefit their practice. Also, master's and doctoral degrees expand the theoretical framework of the professional, who can, in turn, defend the organization of PHC and the recognition of the specialty with a stronger theoretical basis. Research carried out in and by PHC is fundamental to guide FCP's practices since it is performed with similar

communities and populations, producing evidence much closer to the reality of FCM and expanding the studies beyond the hospital logic, which has very different populations and usually includes patients from other health care levels.

Priscila Ferraz Bortolini for ALASF: The introduction of master's and doctoral degrees in FCM/PHC may be the aspect with the greatest deficit of professionals, as FCPs become overwhelmed by several activities, from teaching to management, and have difficulties in specializing and continuing their studies. Graduate training is essential for these professionals to become professors and thus bring more students to FCMRPs. Research is one of the pillars for the demystification of the specialty. It is essential in showing medical society that FCM is an evidence-based specialty.