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ARTIGOS

A curriculum for doctors in Cuba based on political solidarity in the field of health: possible explanation for the work in the "More Doctors" program [1] [2] [3] [4]

Um currículo para médicos em Cuba pela solidariedade política no campo da saúde: possível explicação para a atuação no programa "Mais Médicos"

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Abstract

This aim of this article is to study the formal medical curriculum for the education of Cuban physicians to identify possible explanations for some differences in their practices, already identified by different studies on the "More Doctors Program" (PMM)[5]. To do so, we developed a qualitative, documental and bibliographic exploratory study. Therefore, we defined two reading guide axes for the analysis: (i) the construction of the curriculum and the socio-cultural connection reflected in pedagogical reasoning; (ii) the model of medical education in connection with the health system. We identified characteristics in the curriculum studied that tend towards a decolonial perspective, that is, that the encounter with the "other" is not to dominate, but to support and exchange, from a perspective of political solidarity through health actions, with medical missions. There is a lot of emphasis on comprehensive medicine in the curriculum and it is structured by ethical-humanistic medicine, which is a fundamental perspective for the demands of medical practice in the More Doctors Program.

***Keywords**: curriculum, Cuba, More Doctors program, political solidarity, decolonial*

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Resumo
O presente trabalho tem como objetivo estudar o currículo formal de medicina destinado à formação de médicos cubanos, para identificar possíveis explicações sobre algumas diferenças de suas práticas, já identificadas por diferentes estudos sobre o programa Mais Médicos (PMM). Para tanto, desenvolvemos um estudo exploratório qualitativo, documental e bibliográfico. Para análise definimos dois eixos guias de leitura: (i) a construção do currículo e a conexão sociocultural refletida em raciocínios pedagógicos; (ii) o modelo de educação médica em conexão com o sistema de saúde. Identificamos no currículo estudado características que o aproxima de uma perspectiva decolonial, isto é, o encontro com o "outro" não acontece para dominar, mas para apoiar e trocar, em uma perspectiva de solidariedade política por meio de ações de saúde, com missões médicas. O currículo preza pela medicina integral, estrutura-se por medicina ético-humanista, perspectivas fundamentais para as demandas da prática médica no PMM.
Palavras-chave: *currículo, Cuba, programa Mais Médicos, solidariedade política, decolonial*

Introduction

The shortage of doctors in Brazil, especially in vulnerable areas, is one of the structural problems affecting the Unified National Health System (SUS). We have an insufficient number of physicians per inhabitant in the country[6] – if compared to other countries, – in addition to one more aggravating factor which is the poor distribution of these professionals throughout the national territory (Girardi et al., 2016). There is a clear preference of Brazilian physicians to settle in larger and more economically developed regions. Thus, it is the poorest and/or more remote regions that present greater difficulty in attracting and retaining medical professionals[7] (Stralen, Massote, Carvalho, & Girardi, 2017). The problem takes on an even greater dimension considering that these are precisely the areas that demand greater care, from a social welfare perspective. And these more remote areas are seen as being less attractive to physicians, and present lesser retaining power for these professionals.

[6] At the time the program was created, the Brazilian average was 1.8 doctors/thousand inhabitants. In the case of other countries such as Argentina and Uruguay, the average was 3.2 and 3.7 doctors/thousand inhabitants, respectively. In the United States there are 2.4; in the UK, 2.7; in France, 3.5; in Portugal, 3.9; in Spain, 4; and, in Cuba, 6.4. Moreover, in Brazil, five states were below average, with less than 1 doctor/thousand inhabitants: Acre, Amapá, Maranhão, Pará and Piauí

[7] Translation from Portuguese of: *"Logo, são as regiões mais carentes e/ou remotas que apresentam maior dificuldade de atração e fixação de profissionais médicos"* (Stralen, Massote, Carvalho, & Girardi, 2017, p. 148).

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In response to this question, the "More Doctors Program" (PMM)[8] was created by the federal government. At the time of its implantation, a large part of the population gained access to information about the program through controversial news, which portrayed conflicts between professional entities and the government. The controversy increased with the opening for the participation of Cuban doctors. The arrival of a reasonable number of Cuban doctors[9] to work in the program was one of the most exalted reasons among the attitudes that questioned the PMM. This perspective was then added to the discomfort caused by the exemption granted to foreign doctors (and Brazilians trained outside Brazil) from the revalidation exam of the medical diploma, commonly known as Revalida[10].

However, after more than five years of the PMM, it is a well-known fact that the Cuban doctors maintained the quality of care provided in the country's basic health units, as Franco, Almeida and Giovanella (2018) attest in the analysis on "The Comprehensiveness of the practices of Cuban doctors in the PMM in the city of Rio de Janeiro, Brazil". They reach the conclusion that, in addition to access to medical appointments and the provision of comprehensive health care, the PMM has contributed towards the strengthening of Primary Health Care (PHC). Also in the same study, the authors state that the actions of Cuban doctors took place according to the principles of PHC practices, in a wide range of actions, and which is consistent with the complexity of the health problems encountered. The professionals have a

[8] The "More Doctors Program for Brazil" project (PMM is its acronym in Portuguese) was established by Provisional Measure No. 621, July 8, 2013. Then, with the Interministerial Ordinance No. 1369, July 8th, 2013, the federal government implemented of the "More Doctors Program for Brazil" project. In the same ordinance, it was also defined that the priority municipalities that would receive doctors would be those: either located in areas that were difficult to have access, or that presented difficulty in providing doctors or that presented populations in a situation of greater vulnerability, and which were defined based on the criteria established by Ordinance No. 1.377/GM/ MS, June 13th, 2011, and that met at least one of the following conditions: (i) the municipality has 20% or more of the population living in extreme poverty, based on data from the Ministry of Social Development (MDS) and the Combat Against Hunger, available at www.mds.gov.br/sagi; (ii) being among the 100 municipalities with more than 80,000 inhabitants, with the lowest levels of public revenue per capita and the high social vulnerability of its inhabitants; (iii) located in the area where the Special Indigenous Sanitary District is present (DSEI/SESAI/MS), which is an organ that is part of the Regimental Structure of the Ministry of Health; or (iv) in the areas referring to 40% of the census sectors with the highest municipal level of extreme poverty. The later prerequisite was complemented with the Interministerial Ordinance number 1.493, 18th July, 2013. Law number 12.871, October 2013, which established the PMM and other measures.

[9] The places offered by the Ministry of Health in Primary Care for action, which were not met by Brazilian doctors were available to foreigners duly enrolled in the program said. According to the website of the Ministry of Health, the edicts governing the program were open to foreign doctors who acted in countries with percentages of workers per thousand higher than Brazil's population, this being in our country equal to 1.8. The focus of the federal government were countries like Spain, Portugal and Cuba, due to skills training in primary care and similarity of language. (Moraes, et.al. 2014).

[10] The *Revalida* exam is the name of the exam that recognizes the aptitudes and capacities of doctors trained abroad to act according to Brazilian legislation and medicine. The official name of the test is "National Examination for the Revalidation of Medical Diplomas" issued by Foreign Higher Education Institutions.

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recognized capacity for inclusion in the community, with a focus on disease prevention and health promotion, with a well-structured technical stance, a welcoming attitude and team relationships.

In this context, two aspects call our attention: the first is generated in the context of conflicts and controversies, which is the non-acceptance by Brazilian doctors of the arrival of foreign doctors and the extraordinary measure of exemption of the Revalida exam. The second, based on studies carried out by Santos, Maciel, Lessa, Maia and Guimarães (2016); Terra, Borges, Lidola, Hernandez, Campos (2016), refers to the recognition of the quality of work of the Cuban doctors in the PMM[11], which contradicted all the criticisms. After analyzing several aspects of the implementation of the PMM, authors Santos et al. (2019) conclude that the presence of Cuban doctors around here, in these years, has left strong marks, resulting from a distinct medical culture that is necessary for the Brazilian people. They thus irreversibly influenced the training of future generations of physicians and the organization of services. The authors also say that it is necessary to be inspired by the work of Cubans so that we can effectively advance towards a resolute, universal, comprehensive and equitable health system[12] (Santos et al., 2019).

In this way, our reasoning is that the formal curriculum given to Cuban doctors works as an area for other possibilities, with possible explanations about the qualitatively differentiated performance of these doctors in the PMM. When studying a formal curriculum taught at a medical school in Cuba, we do not intend to characterize a "perfectionist" or "salvationist" path to general medical education. We believe that a curriculum is a political, ethical and aesthetic area that can make a difference in the lives of many people who depend on the curriculum[13] (Paraíso, 2010).

Furthermore, from the perspective adopted here, we understand that this difference has consequences on the lives affected by the medical care received in the contact established via the PMM. The curriculum, used as a discourse (Corazza, 2001), affects and builds lives. It serves to highlight a trajectory marked by skills, conflicts, fights, encounters and choices. The present

[11] It is noteworthy here that the doctors' work within the PMM has always taken place in PHC. Thus, the studies mentioned deal with the quality at this level of care.

[12] Translation from Portuguese of: *"efetivamente avançar para um sistema de saúde resolutivo, universal, integral e equânime"* (Santos et al., 2019, p. 266).

[13] Translation from Portuguese of: *"um currículo é um território político, ético, estético que pode fazer a diferença na vida de muitas pessoas que dependem do currículo"* (Paraíso, 2010, p. 588).

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study then follows a path of intersections, encounters, being attentive to interdisciplinarity: curriculum, medicine, and a health program.

The study begins with a reflection on how the online media publicized the program, because the media presentation of the confrontation between medical corporations and government actions was an instrument to inform the population about the PMM. This was sometimes biased, with political-partisan positions, opposing the government of President Dilma Rousseff. We agree that, despite the small number of articles studied, the media simultaneously acts as a space for the reverberation of political debate and also as a political actor that influences public opinion about the Program[14] (Silva, Rios, Soares, Pinto, & Teixeira, 2018). We then discuss the meaning of PHC for the Brazilian health system, as one of the guiding principles of the PMM is aimed at strengthening this level of care. Finally, we analyze the formal curriculum offered to physicians in Cuba.

Methodological approach

The act of navigating the development of a research presents us with a task of taking a path, which is surrounded by constant reinventing and the giving of new meaning (Paraíso, 2012). When researching, there is a concern with senses, sensibilities, and care for what is said, in an ethical dimension, and methodological commitment. The procedures along the path of research thus respect rigorous and inventive strategies, as going into the field in the scientific environment opens paths for us, which are not always safe, as we research the possibilities of transgression and production of something new. Therefore, we need to be flexible and open to reorganize what we approach (Paraíso, 2012).

The methodological course of the research involved two stages. At first, there was a movement in retrospect, looking for news sites, in order to gather some publications from 2013, considering the following search words: “More Doctor Program”, “Cuban doctors”, “medical entities”. Searching Google by subject and content was a common and accessible way to identify the first stories that dealt with the PMM in the year of its launch. The portals chosen were *O Globo, Jornal do Comércio* and *EBC* (Empresa Brasileira de Comunicação), as they were the first

[14] Translation from Portuguese of: “a mídia atua simultaneamente como espaço de reverberação do debate político e, também, como um ator político que influi na opinião pública acerca do Programa” (Silva, Rios, Soares, Pinto, & Teixeira, 2018, p. 499).

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to appear in the search list. While reading, we investigated the main arguments and contents disseminated about the PMM, related to the coming of Cuban doctors to Brazil. Then, with the purpose of complementing the findings of this first search movement, we searched the *SciELO Brasil* – Scientific Electronic Library Online – site for articles that contained, the following descriptors: "media" and "More Doctors Program", either in their title or in their abstract. Only two articles were found, namely: the one by Morais et al. (2014) to analyze publications related to the PMM from July to September 2013 in the *Correio Braziliense* and *Folha de S.Paulo*; and Silva et al. (2018), whose objective was to explore the repercussion of the launch of the PMM in the media and the information disseminated about the education of physicians in Cuba.

We searched for the Pedagogical Course Projects (PPC)[15] on the websites of Cuban universities, however, after several attempts, the strategy was not successful. We then made direct contact with the PMM management supervision bodies in Minas Gerais, by e-mail[16]. Access to documents took place in October, 2018.

The curriculum as a discourse, as language, as observed by Corazza (2001), is also made with historically and socially constructed images, representations, metaphors, and which embodies knowledge, norms, moral prescriptions, regulations, programs, relationships, values, ways of being of the subjects, in institutions[17] (Corazza, 2001). Curriculum studies from a post-critical perspective are not intended to be normative or prescriptive, they do not represent a general doctrine of what is considered 'good to be', nor a body of immutable principles of what is considered 'right to do'[18](Corazza, 2001). Based on this access, we approached and expanded our view of the curriculum that trains doctors in Cuba. We thus seek to find other experiences, other forms of learning, other ways of life (Paraíso, 2018), by understanding the curriculum as a discourse; a cultural artifact produced in a historical-political-cultural context.

At this point of the research, we entered the dimension of the official/formal curriculum, as we will study guidelines, prescribed principles, regulations and official plans, in

[15] Translation from Portuguese of: *projetos pedagógicos de curso* (PPC)

[16] The research was submitted to the Research Ethics Committee of the Federal University of Minas Gerais (UFMG), according to Resolution No. 466, December 2012. Approval in November 2018 with favorable sentence number: 3,021,804.

[17] Translation from Portuguese of: *"corporifica em instituições, saberes, normas, prescrições morais, regulamentos, programas, relações, valores, modos de ser dos sujeitos"* (Corazza, 2001, p. 10).

[18] Translation from Portuguese of: *"não constituem uma doutrina geral sobre o que é 'bom ser', nem um corpo de princípios imutáveis do que é 'certo fazer'"* (Corazza, 2001, p. 56).

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what we call PPC or, as it is called in Cuba: Training Plan for a Career in Medicine in Cuba. The area of our study is, therefore, a curriculum that embodies a prescribed proposal with contents organized to follow a temporal sequence.

In reading the documents, our great care was to research historical characteristics that structured the curriculum and which were prior to 2015. To do so, we returned to the main guidelines that train doctors in Cuba – which could explain their work in the PMM.

In view of the complexity of possibilities involved in the curriculum debate, we chose two main axes to be identified in the documents: (i) the construction of the curriculum and the sociocultural connection reflected in the pedagogical reasoning and directing guidelines; (ii) the medical education model in connection with the health system (the place of PHC). By establishing these guidelines in the study, it was possible to identify: elements of Cuba's history and their role in shaping the curriculum of universities; characteristics of the Cuban health system; and sociocultural characteristics to understand how the curriculum operates with characteristics of a comprehensive health education model[19].

A brief presentation of the More Doctors Program as per the perspective of the media

Since its inception, the PMM has had had repercussions in several sectors and has suffered great resistance from medical entities. One of the consequences was the low adherence of Brazilian professionals to the program. In order to direct actions towards this issue, the federal government allowed the incorporation of foreigners. Thus, there was an opening for and coming of Cuban doctors − in 2015, there were already 18,000 professionals, which represented 79% of the Cuban doctors within the program (Franco, Almeida, & Giovanella, 2018).

The controversies and clashes arising from bodies of professional entities (unions, associations, national federations, medical foundations, etc.), some students and opinion makers were reported in different media: TV news, printed newspapers and online media. In 2013, the

[19] Integrality, as an organizational principle of PHC, allows for the continued attention and monitoring of people, and which can enable a necessary revolution in medicine (Tesser, & Luz, 2008).

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year the program was launched, there were demonstrations, contrary reactions and work standstill registered in 12 Brazilian states: Goiás, Espírito Santo, Maranhão, Ceará, Amazonas, Rio Grande do Sul, Paraná, Minas Gerais, Rondônia, Rio de Janeiro, Sergipe and Acre, in addition to the Federal District. The most controversial topic was the opening of positions in the Unified National Health System to foreign doctors, which generated a strong opposite reaction from the Medical Entities (ME), to the point of threatening the government with the outbreak of a strike by doctors[20] (Silva et al., 2018).

The Federal Council of Medicine (CFM)[21] considered, at the time, that more doctors were not needed, but rather a policy of redistribution of professionals throughout the national territory. In a statement, the National Federation of Physicians (Fenam) considered that the PMM was going against labor laws, and denounced the lack of adequate working conditions in the municipalities, such as lack of infrastructure, X-rays, medication and stretchers (Rodrigues, 2013b).

One of the most debated problems since the creation of the PMM was the hiring of foreigners without the obligation of applying the proof of revalidation of the diploma. This is evident in the excerpt from the *EBC* Portal's report called: Medical class diverges on government project for hiring foreigners[22]:

> … According to the adviser of the Federal Council of Medicine, Mauro Ribeiro, the manifestation would have arisen spontaneously and is not against the arrival of foreign doctors, but against the fact that, according to the project, new professionals will not be submitted to the revalidation process of the diploma[23] (Rodrigues, 2013a).

At the same time, the same article presents an analysis from a researcher at the Federal University of Minas Gerais (UFMG), Dr. Sábado Nicolau Girard who stated the movement against the measure is an outdated corporate reaction … the exceptionality of the case allows for the occurrence of a distinct exam. When giving an opinion on the

[20] Translation from Portuguese of: O tema mais controverso foi a abertura de postos de trabalho no SUS para médicos estrangeiros, o que gerou, por parte das Entidades Médicas (EM), uma forte reação contrária, a ponto de ameaçarem o governo com a deflagração de uma greve dos médicos (Silva et al., 2018, p. 494).

[21] Abreviation from Portuguese of: Counselho Federal de Medicina.

[22] Title in Portuguese: "Classe médica diverge sobre projeto do governo para contratação de estrangeiros"

[23] Translation from Portuguese of: … Segundo o conselheiro do Conselho Federal de Medicina, Mauro Ribeiro, a manifestação teria surgido de forma espontânea e não é contra a chegada de médicos estrangeiros e sim com o fato de que, pelo projeto, os novos profissionais não serão submetidos ao processo de revalidação do diploma (Rodrigues, 2013a).

subject, Sábado considers a study carried out under his coordination, which points out the shortage of medical professionals in 1,304 Brazilian municipalities (Rodrigues, 2013a).

The same theme is addressed in news from the Minas Gerais *G1* portal, on August 29, 2013, with the following title: the CRM of the state of Minas Gerais, Brazil, cannot deny registration to foreign doctors, a judge so decides: the Council did not want to issue registration to the More Doctors professionals. Judge considers the request a 'battle' of market reserve.

> … He also highlights that the provisional measure provides for the priority of doctors trained in Brazilian higher education institutions or with a diploma revalidated in the country. In other words, only vacancies not filled by Brazilian diplomas or revalidated in the country will be filled by foreigners…. In the decision, the magistrate states that despite the CRM-MG having said in the initial petition that it is not against the presence of foreign doctors in the country, by trying to deny the professionals' records, the Council is … instigating a real "battle" aimed at preservation of a market reserve for doctors trained in Brazilian higher education institutions or with diplomas revalidated in the country … and the victims, unfortunately, are the patients and users of public system entities[24]. (Andrade, 2013).

The *O Globo* newspaper (Remigio & Paula, 2013) informed readers, in a critical tone, about the launch and official status of the PMM with an article presenting the following title: In Health, measures proposed by Dilma are no longer new. President insists on creating new courses and importing doctors. The article comments that the ministers Mercadante (Education) and Padilha (Health) went to Congress to publicly defend the coming of foreign doctors to Brazil, in order to provide emergency care in the Unified National Health System (SUS), in municipalities in the rural areas and on the outskirts of the major cities. According to a similar research, Morais et al. (2014), analyzing the headlines of the *Folha de S.Paulo* and *Correio Braziliense* newspapers, identified 110 negative stories in the first newspaper and 178 in the second, against 50 publications with a neutral position regarding the PMM.

Regarding the arrival of Cuban doctors, a common characteristic is evident in the aforementioned articles: a set of opinions questioning the relationship between the quality of services provided, without the *Revalida* exam, and the training of Cubans. However, after more

[24] Translation from Portuguese of: … Ele destaca, ainda, que a medida provisória prevê a prioridade dos médicos formados em instituições de educação superior brasileiras ou com diploma revalidado no país. Ou seja, apenas as vagas não preenchidas por diplomas brasileiros ou revalidados no país é que serão preenchidas por estrangeiros …. Na decisão, o magistrado afirma que apesar de o CRM-MG ter dito na petição inicial que não é contra a presença dos médicos estrangeiros no país, ao tentar negar os registros dos profissionais o Conselho está … instaurando uma verdadeira "batalha" visando a preservação de uma reserva de mercado aos médicos formados em instituições de educação superior brasileiras ou com diplomas revalidados no país … e as vítimas, lamentavelmente, são os doentes e usuários dos órgãos do sistema público. (Andrade, 2013).

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than five years, the results of the work of those professionals in the PMM proved to be justifiable, more than satisfactory. The program has gone beyond increasing the number of appointments available (Girardi et al., 2016) and has contributed to reducing inequities in the distribution of physicians (Brasil, 2015).

In this scenario, some researchers believe that the majority of the population received information about the PMM based on stories that had a superficial approach or contrary positions. It was found that the media is fundamental for the impact of the Program, but the truth is not apparent, only the opinion of journalists who wrote the stories related to the theme (Morais et al., 2014, p. 107).

Thus, the presentation of the PMM based on reading the news consulted, in its first year, shows little clarification regarding the role of Cuban doctors, and was sometimes even biased due to the country's political system. A Cuban doctor interviewed, in December 2018, about the end of cooperation with Brazil, with the election of the Bolsonaro government stated the following: our roots seem to have thorns for this moment in Brazil, but our mission is care, meeting health needs, it is solidarity with Brazil[25] (Cuban doctor, verbal information, 2018)[26] .

In addition to the fact that the media did not go deeper into the training of Cuban doctors and the space for their insertion in the Brazilian health system, it should be emphasized that there are few studies in the country about the Cuban health system and the education of its doctors. When searching the *SciELO Brasil* library database for the terms "Cuba" and "health" and "Cuba" and "doctors", a gap was confirmed between studies on the subject (Gomes, Merhy & Ferla, 2018). Concomitantly, in opposition to criticism in the common media, we found the recognition of an interrelation between the quality of these doctors' education and the importance of their work with PHC in studies on the subject.

[25] Informal translation from Portuguese and Spanish as the doctors interviewed, despite mixing words in both Portuguese and Spanish, had already developed easy to understand communication.

[26] The present work is the result of a larger research, carried out during a doctoral internship with the support of the National Council for Scientific and Technological Development - CNPq. Part of the methodology was to conduct semi-structured interviews.

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Primary Health Care Attention as an area for the More Doctors Program and a structuring function of the Brazilian health system.

PHC does not have roots in Brazil. Its modern construction dates back to 1920, with the publication of the Dawson Report, an English document that opposes the Flexnerian paradigm[27] (Fahel, Silva, & Oliveira, 2018), also known as biomedical. Already during this period, the report foresaw, according to the principles of primary care, that the care model should be organized in health centers, with home service, regionalized care, so that most problems would be solved by general practitioners. The hierarchy of services was also planned, so that if something was not solved in the PHC, the secondary care levels would be referenced, which would have specialist doctors, or hospitals, for hospitalization or surgery (Matta & Morosini, 2009).

By analyzing the Brazilian health system historically, we realize that, for a long time, its structure has been centered on the hospital and the disease[28]; which starts to change with the creation of the SUS and the Family Health Program (PSF)[29]: the institutionalized place of PHC in the Brazilian health system. In this way, it is possible to identify two PHCs, with interdependent aspects: a strategy for the organization and reorganization of health systems, in which it represents the first level of care, and also a model of change in the clinical-care practice of health professionals[30] (Oliveira & Pereira, 2013). Considering the theoretical meaning of PHC – even if its implementation in practice is still a challenge – in this area, actions are carried out

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[27] "In 1910, the study known as the Flexner Report was published and is considered to be largely responsible for the most important medical school reform of all times in the United States of America (USA), with profound implications for medical education and world medicine. Disease is considered a natural, biological process…. Hospitals became the main institution for the transmission of medical knowledge throughout the 20th century. Laboratory teaching in the basic areas (anatomy, physiology, pathology) and the theoretical part of specialties is left to the Faculties (Luz, 1993) The postures are admittedly positivist, pointing to scientific knowledge, through observation and experimentation as being the only safe knowledge" (Pagliosa & Da Ros, 2008, p. 496).

[28] "If the 'hospice' or 'insane asylum' embodied in the history of our culture medical separation and segmentation in its most antiquated, hard and collective format, the modern 'hospital' updates this trend in mild and technically irreproachable ways" (Duarte , 2003, p. 178).

[29] The Family Health Strategy (ESF) is priority coordination for the expansion, strengthening and restructuring of the PHC. Since its establishment in 1994, first as the Family Health Program, several challenges have been faced to reach an expressive degree of problem-solving capacity and improve the health status of the Brazilian population. The underfunding of actions, the difficulty of hiring and retaining health professionals - especially doctors -, the insufficient qualification of workers, budget competition with medium and high complexity, among other factors, stand out (Almeida, Macedo, & Silva , 2019).

[30] Translation from Portuguese of: *"uma estratégia de organização e reorganização dos sistemas de saúde, nos quais representa o primeiro nível de atenção, e também um modelo de mudança da prática clínico-assistencial dos profissionais de saúde"* (Oliveira & Pereira, 2013, p. 154).

aimed at the community, the family, without limiting individual care; the work process has specific characteristics that differ from other levels of care. Health is the focus, not the disease. Actions are guided by social, cultural and epidemiological criteria, which include health promotion activities through educational actions between the health team and the community.

In PHC, the work is with the person and their family. This infers that the doctor knows the patient by name, knows the community, the territory (region) served, its main problems; thus, care demands regular time and care from the health team, from the perspective of longitudinal care. Consequently, care/service/monitoring by professionals from the medical team would not end, therefore, in a traditional consultation in a basic health unit, but would continue throughout the life of the system user (Fahel, Silva, & Oliveira , 2018).

According to Starfield (2001) and Mendes (2011), PHC has structuring characteristics and functions that contribute towards the proper functioning of the entire health system, due to its being the first contact in the system; which should occur based on the characteristics of longitudinality; of comprehensiveness; system coordination; focus on the family; community orientation and cultural competence. Within the scope of functions, there is resolvability, communication and accountability.

By being considered the gateway to the health system, the PHC takes on among other functions, the responsibility of welcoming and initiating, in a humane and educational way, the health care provided to the population. And, when necessary, articulate with the other levels of care that make up the Brazilian health system[31]. PHC should provide support throughout time, so that it can monitor and provide continuity of care, in order to promote the health of the assisted population, which is the very practice of longitudinality. For Starfield (2001), this is recognized as a central and exclusive feature of PHC, which means the monitoring of the patient along the course of time by a general practitioner or team, for multiple episodes of illness and preventive care (and health promotion) (Cunha & Giovanella, 2011).

In addition, it is expected that, in PHC, the care is based on the dimension of comprehension[32], which can be associated with teamwork to provide care, following the promotion, prevention, cure, care and rehabilitation, as well as the recognition of health

[31] See Decree number 2,488, dated 21st Octiber, 2011
[32] Anderson, & Rodrigues (2016) develop a debate on the effectiveness of integral medicine, health and illness and integrality.

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problems as defined by biological, psychological and social reasons. The management capacity to guarantee the continuity of care – which requires constant articulation and communication between the different levels of care – is PHC coordination itself. The *Communication* that provides for community participation. The subject of attention, in PHC, is the family in connection with the community/territory in which it resides, which requires greater interaction between the team and this social unit. *Cultural competence* proposes that there be a horizontal relationship between the team, professionals and the community that respects the cultural singularities and preferences of individuals and families (Mendes, 2011).

Law No. 12,871, which established the PMM, specifies that it be structured along major axes, with objectives that revolve around the strengthening of PHC and medical training. In the structuring of the program the expectations are: a reduction of regional inequalities regarding the shortage of doctors; a strengthening of Primary Health Care in the country; an expansion of the insertion of the doctor in the health reality of the Brazilian population, with practices in basic health units (UBS), as part of the training process; an implementation of teaching-service integration in order to strengthen the permanent education policy, with academic supervision of the activities carried out; an exchange of knowledge among health professionals; a contribution towards the improvement of Brazilian physicians to work in public health policies; encouragement to carry out research applied to the SUS.

The PMM foresees that doctors, both Brazilian and foreign (Cuban), are included in the Family Health Strategy, the locus of PHC[33]. Madureira (2010), in a study on the Cuban Health System, considers that the basic characteristic, for the profile of these doctors to be general practitioners, is training with great attention directed towards work according to the PHC principles. In line with this statement, we proceeded to study the formal curriculum given to physicians in Cuba.

[33] There was a conditional rule for all physicians working in the PMM, which was participation in a specialization course.

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Up to now, we have gone back on some of the pathways that lead us to the curriculum for doctors in Cuba. Along this path, we are clear about the presence of different alternatives and "gateways" in the study of the curricula. There is the one developed by political reasoning, when one asks about power relations, political arrangements, conflicts, alliances, and choices. At the entrance of the cultural thought system, paths will be followed to study the curriculum that cross through preferences, silences, ways of life and differences. Finally, we can enter the area of the curriculum through the entrance that connects it to dimensions of *pedagogical reasoning*, that is, to criteria of organization, content selection, planning of what to teach, what to evaluate and how to evaluate (Paraíso, 2018). Even though the main focus is on the dimensions that guide pedagogical strategies (or curricular principles), the other two dimensions meet and intertwine in this same space, which is the curriculum – as a social artifact.

The setting up of medical courses in Cuba dates back to the 18th century, in the colonial period. At that time, curricula were guided by the theory and practice dichotomy and learning was centralized at the hospital (Universidad de Ciencias Médicos de la Habana, 2015a, 2015b). According to Vela-Valdés et al. (2018), before 1959, there was only one School of Medicine in the country, founded in 1728, and a School of Dentistry, founded in 1900, both located in the capital[34]. The authors draw our attention to the fact of access being limited due to high prices. Many of the medical graduates would have to migrate to find work. With regard to the training model written in the curricula, a curative perspective essentially prevailed.

> entrance was limited due to the cost of enrollment and the high prices of books of texts, and graduates, whose labor market was in the provincial capitals, had to emigrate from the country. The study plans were theoretical and essentially curative, focused only on the biological aspects of illness and professional preparation for private practice, lacking a social focus on health[35] (Vela-Valdés et al., 2018).

[34] Translation from Spanish of: Antes de 1959, solo existía una Escuela de Medicina en el país, creada en 1728, y una Escuela de Odontología, fundada en 1900, ambas ubicadas en la capital. (Vela-Valdés et al., 2018, p. 1)

[35] Translation from Spanish of: ingreso era limitado por el costo de la matrícula y los altos precios de los libros de textos, y los egresados tenían como mercado laboral las capitales provinciales o debían emigrar del país. Los planes de estudios eran teóricos y esencialmente curativos, se enfocaban solo en los aspectos biológicos de la enfermedad y preparaban al profesional para la práctica privada, carente del enfoque social de la salud (Vela-Valdés et al., 2018, p. 1-2).

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The revolutionary triumph of 1959[36] produced radical changes and, among them, medical care came to be guaranteed as a social right and its orientation became preventive-curative, with an emphasis on prophylactic aspects. On the other hand, as a result of the Cuban Revolution, there was a significant exodus of doctors (Universidad de Ciencias Médicos de la Habana, 2015a). Before the revolution there were about six thousand doctors in Cuba; then, after 1959, about three thousand remained[37]. The problem takes on a greater dimension, as dropouts were more intense among medical professors. Thus, in 1962 the country had only 16 medical professors. And it was from those who remained that they massively trained new doctors[38] (Gomes, Merhy, & Ferla, 2018).

> *El éxodo de médicos a raíz de las primeras medidas revolucionarias, llevó a ampliar la formación de nuevos profesionales para cubrir las necesidades de todo el pueblo. En la década del 60 se fundó el Instituto de Ciencias Básicas y Preclínicas "Victoria de Girón" y las Facultades de Medicina de Santiago de Cuba y Santa Clara, con el concurso de un escaso número de profesores que asumieron la responsabilidad de la formación en número creciente de médicos[39] (Universidad de Ciencias médicas de la Habana, 2015a, p. 3).*

The organization, planning and training of professionals in the Cuban health area, since the 1960s, are guaranteed by the national health system itself. In 2017, Cuba had 13 universities with a degree in Medicine and two independent faculties, the *Escuela Latinoamericana de Medicina* (ELAM) and the *Escula Nacional de Salud Publica*. In the 2014-2015 academic period, 52,235 undergraduate students were enrolled in the area. In 2015, Cuba had 7.7 doctors for every thousand inhabitants, which corresponds to one doctor for every 130 inhabitants. In 2015, there was recognition by the World Health Organization that Cuba had eliminated vertical transmission of HIV and syphilis (Alves, Oliveira, Matos, Santos, & Delduque, 2017).

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[36] "A partir de 1959 en todas las universidades la matrícula y la adquisición de los libros de textos se tornaron gratuitas, lo que posibilitó progresivamente la masificación del ingreso a estos estudios. Esto condujo a la necesidad de universalizar y extender la formación de los estudiantes de ciencias médicas a todas las provincias del país, por lo que se estableció el plan de becas universitarias" (Vela-Valdés et al., 2018, p. 2).

[37] According to Dal Prá, Minelli, Martini, Fetzner, & Fontana, (2015) despite the shortage of professionals, the Cuban government invested significantly in the training of human resources, a fact that, added to the political will, the right of the citizen and the responsibility of the State, became the basis for the transformation of the Cuban national health system

[38] According to Gomes, Merhy and Ferla (2018), in 1999, four decades after the implantation of the revolution, 64,863 doctors worked in Cuba – one for every 175 inhabitants.

[39] Translation of Spanish citation: The exodus of doctors as a result of the first revolutionary measures, led to the expansion of the training of new professionals to meet the needs of all the people. In the 1960s, the "Victoria de Girón" Institute of Basic and Pre-clinical Sciences and the Santiago de Cuba and Santa Clara Faculties of Medicine were founded, with the assistance of a small number of professors who took on the responsibility for educating a growing number of doctors (University of Medical Sciences of Havana, 2015a).

Throughout history, the curricular development of medicine courses in Cuba – as presented in one of the documents analyzed, called *Plan de estudio D, Carrera Medicina: Fundamentacion* – has undergone some changes. From 1962 to 1980, there were five study plans for medicine. The document leads us to understand that only one curricular orientation was defined. The Ministry of Education, after conducting a nationwide study, raised demands arising from the Cuban health and medical education situation, as well as deficiencies and perspectives. In addition to the results, a new curriculum was drawn up in 1984 with the aim of training a general (clinical) doctor who will work as a family doctor in the communities (Universidad de Ciencias Médicos de la Habana 2015b).

But what does a general practitioner mean in Cuba's curriculum? What proposals inherent in this curriculum will help to train a family doctor? How long does a medical degree in Cuba last? The model for training a general practitioner, according to the document studied, includes three dimensions: ethical-humanist; professional; and occupational (Universidad de Ciencias Médicos de la Habana, 2015a).

In the curriculum, the ethical-humanist dimension seems to articulate the other two (professional and occupational). Thus, according to the curricular proposal, the values inherent in the training of physicians in Cuba seek to escape that Western model, traditionally made up of a tendency towards strong specialization and based primarily on scientific/Cartesian principles. In addition to this aspect, the curriculum aims at training towards a concern with the community, with the extended family, with caring for people and not just treating disease.

In Cuba, as in Brazil, the undergraduate medical course lasts for six years. The time period of the medical studies plan is 6 years. The subject of professional training represented by the main integrating discipline extends to all the semesters[40] (Universidad de Ciencias Médicas de la Habana, 2015b). During this period, training is organized into academic periods and another year of internship. To graduate, students must pass a national exam, when they take a practical and a theoretical test, with the aim of proving their established professional competences. Participation in the exam can only take place after the examinee has passed all the disciplines of the internship. Physicians are prepared to carry out activities based on

[40] Translation from Spanish of: "La duración del plan de estudios de Medicina es de 6 años. Su eje de formación profesional representado por la disciplina principal integradora se extiende en la totalidad de los semestres" (Universidad de Ciencias Médicas de la Habana, 2015b, p. 8).

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comprehensive care at all stages of the individual's and family's life cycle, by means of actions for comprehensive health[41] (Pan American Health Organization, 2018).

One of the characteristics of PHC is Comprehensiveness, as we saw in Starfield (2001). It is a concept that encompasses several aspects of the work process in the sense of being an articulator of a care network, which includes care with health promotion and prevention actions and care for the rehabilitation of the population's health (Comes et al., 2016). The professional and occupational profile proposed foresees: Comprehensive and continuous medical care through actions to promote health, prevention of diseases and other damages to health, timely diagnosis and treatment, and rehabilitation[42] (University of Medical Sciences of Havana, 2015a, p. 8).

In addition to the sense of integration set in motion in the curriculum for physicians, Cuba foresees, for example, in its pedagogical reasoning, methodologies, activities and the development of skills that direct care for the individual and their family, as a person and not as a disease. Integration is also inherent in the expanded concept of health, which includes the social, cultural, economic, political and environmental dimensions of the health-disease process. And also directs the attention to each individual and family in a complete way, considering environmental and epidemiological risk conditions. Such characteristics can be identified in several aspects of the studied curriculum, since comprehensive care is characterized as a guiding role of five other functions and teamwork: *se definen cinco funciones para el Médico General, siendo la función rectora la de Atención Médica Integral: Atención médica integral; docente-Educativa; Administración; Investigación; Especiales*[43] (Universidad de Ciencias Médicas de la Habana, 2015a, p. 8). In other words, the curriculum that trains doctors in Cuba includes comprehensive medical care, teaching, investigative and administrative care, in addition to working in special situations such as disasters (Pan American Health Organization, 2018).

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[41] Comprehensiveness is a guideline of the SUS in Brazil. It is determined both at the level of health work and in the sphere of policies capable of intervening in the drivers of the health-disease-care process to guarantee satisfactory conditions of wellbeing. The comprehensiveness of practices in primary health care involves a biopsychosocial approach to care for individuals and families, (Franco, Almeida, & Giovanella, 2017, p. 2).

[42] Translation from Spanish of: *"atención médica integral y continua mediante acciones de promoción de salud, de prevención de enfermedades y otros daños a la salud, de diagnóstico y tratamiento oportunos, y de rehabilitación"*[42] (Universidad de Ciencias Médicas de la Habana, 2015a, p. 8).

[43] Translation to Spanish of: five functions are defined for the General Doctor, where the guiding function is that of Comprehensive Medical Care: Comprehensive medical care; teacher-educational; Administration; Investigations; Special functions (Universidad de Ciencias Médicas de la Habana, 2015a).

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Political solidarity in health is also another foreseen dimension, since the curriculum is not limited to training doctors to serve only the island. Thus, it provides for the curriculum that the Cuban doctor must, among other responsibilities, be trained to face:

> *las realidades del planeta relacionadas con los peligros que ponen en riesgo su sostenibilidad. En su desempeño como profesional: actuará en función de los intereses de la sociedad y de la satisfacción de las crecientes necesidades de salud del pueblo. Estará dispuesto para actuar ante situaciones de desastres.*[44] (Universidad de Ciencias médicas de la Habana, 2015a, p.7).

The political action of solidarity for health consists of a strategy built in Cuba with the use of internationalist missions, to send health professionals, especially doctors, to other nations that are experiencing disaster, epidemics or other health needs situations. Since the first mission, in 1962, until 2011, Cuba has sent around 132,000 health professionals on solidarity missions in more than 100 countries. In 2011, 69 countries were served by 31,000 professionals. The Cuban mission in Haiti has reduced infant mortality from 42 to 16 per thousand live births in some areas (Castro, 2007; Gomes, Merhy, & Ferla, 2018). Finally, through medical care, no matter that there is a dimension of political relationship between nations in this discourse, it is also clear that the encounter with the "other" will not be to dominate, but to support and exchange. We identified that the mission is not there for war/power or to "evangelize", as the colonizers did. It is for life and health. From this perspective, we identify an opposition to the mercantile character in the curriculum, which transforms health into a commodity. The expected solidarity is linked to a type of welcoming of the other, which is capable of promoting exchanges in encounters between different beings and knowledge, meanings and practices[45] (Walsh, 2005, p. 45). And not for power, Nascimento & Garrafa (2011). This political action of solidarity is called, by Gomes, Merhy and Ferla (2018), a subjective construction of a revolutionary doctor[46]. The revolutionary character is precisely in training doctors for the work of internationalist

[44] Translation of citation in Spanish: the realities of the planet related to the dangers that put its sustainability at risk. In their performance as a professional: they will act according to the interests of society and the satisfaction of the growing health needs of the people. They will be ready to act in disaster situations[44]. (University of Medical Sciences of Havana, 2015a, p.7 - Universidad de Ciencias médicas de la Habana).

[45] Translation from Portuguese of: *"capaz de impulsionar intercâmbios em encontros entre seres e saberes, sentidos e práticas diferentes"* (Walsh, 2005, p. 45).

[46] Which, according to the authors, does not represent a complete break with the scientific perspective. And it even comes closer to that Foucaultian definition of the myth of the extinction of diseases, the government of the entities and cities, coming from medical power.

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missions, as an act of solidarity, honor and assistance to the most needy people. An ethical response, therefore, against the imperialist logic, which dominates and subjugates.

In opposition to the biomedical model[47], the formal curriculum in Cuba is guided by a perspective that in its way defends solidarity, reproduced in humanitarian health work ethics. In this way, the doctor is expected to: … act according to the principles of medical ethics and will mitigate his actions, as a doctor and as a citizen, to the demands of the historical moment and the place where he provides his services[48](Universidad de Ciencias Médicas de la Habana, 2015a, p.7).

Furthermore, it should be noted that there is a discourse of "discipline" of social life, by placing medical knowledge in a place of power in social organization, in the formal curriculum for Cuban physicians, (Gomes, Merhy, & Ferla, 2018). However, we emphasize that there is no space in the studied curriculum to establish a relationship of superiority or domination or status in the relationship between doctor and community, or even between doctors and the health team. The values mentioned in what would mean the "humanist ethical spirit", within the studied curriculum, refer to the denial of any elitist position, in work that detaches itself from mercantilist feelings, focusing on the spirit of solidarity in any part of the world.

> *Desarrollará un sistema de valores que le permitan demostrar una clara concepción de su papel como profesional al servicio del pueblo, alejado de posiciones elitistas, despojado de sentimientos mercantilistas con respecto al desempeño de la profesión, con un elevado espíritu de solidaridad, dispuesto a tratar a los demás sin distinción como seres humanos y a prestar sus servicios en cualquier parte del mundo que sean necesarios*[49] (Universidad de Ciencias médicas de la Habana, 2015a, p. 7).

[47] For a better understanding of the meaning of the biomedical model, we present some characteristics: little consideration for the physician-patient relationship as a fundamental element of therapy; the search for complex therapeutic means using expensive technology; little investment in patient autonomy; affirmation of a medicine that has the category of illness and not health as a central category of its paradigm (Luz Madel, 1997, p. 28). In the biomedical model, there is "the knowledge produced by scientific disciplines in the field of biology" (Camargo Jr., 1997). Thus, the way of being a doctor is centered on a medical practice that, in an attempt to be scientific, detaches itself from the subject (Romano, 2008).

[48] Translation from Spanish of: *"Actuará conforme a los principios de la ética médica y atemperará sus acciones, como médico y como ciudadano a las exigencias del momento histórico y el lugar donde presta sus servicios"* (Universidad de Ciencias Médicas de la Habana, 2015a).

[49] Translation of citation in Spanish: A system of values will develop that allows you to demonstrate a clear conception of your role as a professional at the service of the people, away from elitist positions, stripped of mercantilist feelings regarding the performance of the profession, with a high spirit of solidarity, willing to deal with the others without distinction as human beings and to provide their services in any part of the world that are necessary[49] (University of Medical Sciences of Havana, 2015a).

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By emphasizing a pattern contrary to global capitalist power; by distancing themselves from relations of exploitation or dispute in the context of health care – when a priority to train doctors for solidarity missions is set; by valuing learning also focused on the internal culture and history of Cuba and the Revolution: the Cuban medical education curriculum takes on an alternative path. Which, in our view, brings it closer to a decolonial pedagogical perspective.

Therefore, historically, Cuba and the Revolution represent a different narrative, which is possible to detect in the construction of the studied curriculum. In the modes of subjectivation, there is an intrinsic presence of different types of knowledge and know-how, when involving the community under care. Factors and sociocultural characteristics are observed due to a denial of the imperialist capitalist logic, when proposing, for example, medical training with actions aimed at internal issues and also for needy populations in other countries. Or by recognizing the importance of community knowledge, traditional medicine, using medicinal plants approved in the health system; using comprehensive medicine; with traditional Asian medicine activities, such as acupuncture, as long as they are authorized in the centers provided for this purpose.

Decoloniality is a response to the historical process of colonization, domination and modernity: experienced in coloniality. Colonialism and coloniality are intertwined concepts, the latter being characteristic of modernity (Mignolo, 2017). From a decolonial perspective, pluriversal as opposed to the universal is a guideline and is not based on rivalry options. In this place, let it be a relationship where no human being has the right to dominate and impose himself on another human being[50]. Which means changes. Not just speech and content, but action and reflection (Mignolo, 2017).

The Revolution in Cuba transformed the country in several dimensions, which have interrelationships (Gomes, Merhy, & Ferla, 2018). Thus, we say that in Cuba there is a process of subjectivation, a discourse aimed at the "other", which in the training of doctors reverberates in solidarity. Cuba does not train doctors just for the island. Cuba trains doctors for the world. Its curriculum for training physicians pays attention to the dimension of care that elects, for itself, the thought-of–the-other. What is done with the struggle against non-existence, dominated existence and dehumanization…. In opposition to the proposal based on the

[50] Translation from Portuguese of: "onde nenhum ser humano tem o direito de dominar e se impor a outro ser humano" (Mignolo, 2017, p. 14).

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coloniality of being concept, a category that serves as a power to question the historical denial of the existence of non-Europeans[51] (Oliveira & Candau, 2010).

In other words, we can identify such a dimension amid the pedagogical reasoning in the curriculum that trains doctors in Cuba and its context of development, associated with an essential vision in the health/revolution relationship, which projects far beyond the teaching and transmission processes of knowing[52] (Oliveira & Candau, 2010). Still, it conceives medicine as one of the alternatives to being a doctor, the exercise of a humanitarian cultural political practice. Finally, it also presupposes development and creation. Its goal is the radical reconstruction of being, power and knowledge[53] (Oliveira & Candau, 2010).

It is important, however, to make a brief observation[54] on the process of *diplomacy through medicine* in Cuba or, in another way, *Cuban health geopolitics*. To what extent would the initiative of sending doctors to other countries yield gains for Cuba? In response to this question, in Feinsilver's (2008) brief analysis, the economic benefits of exporting physicians are considered. In the analyzed case of the relationship between Cuba and Venezuela, the commercial agreement, in which doctors were exchanged for oil, as a strategic way of sustaining the economy in Cuba, draws our attention.

> Trade with and aid from Venezuela in the oil-for-doctors exchange, has bolstered Cuba's ability to conduct medical diplomacy, and more importantly, has helped keep its economy afloat. Earnings from medical services (which include the export of doctors) equaled 28 percent of total export receipts and net capital payments in 2006. This amounted to US$2,3 million. This implies greater benefits than that for both nickel and cobalt exports and tourism. In fact, the export of medical services is currently seen as the most prosperous business on Cuba's economic horizon[55] (Feinsilver, 2008).

[51] Translation from portuguese of: "luta contra a não-existência, a existência dominada e a desumanização …. Em oposição à proposta pelo conceito de colonialidade do ser, uma categoria que serve como força para questionar a negação histórica da existência dos não-europeus" (Oliveira & Candau, 2010, p. 24).

[52] Translation from Portuguese of: "que se projeta muito além dos processos de ensino e de transmissão de saber" (Oliveira & Candau, 2010, p. 28).

[53] Translation from Portuguese of: "supõe também construção e criação. Sua meta é a reconstrução radical do ser, do poder e do saber" (Oliveira & Candau, 2010, p. 24).

[54] The training of doctors as an export alternative is not the main theme of our study. However, this is a fundamental question, which is connected to training. In this way, we could not fail to mention it, even if briefly.

[55] Translation from Spanish of: El comercio con Venezuela y el acuerdo de intercambio de médicos por petróleo le ha permitido expandir su diplomacia médica y, lo más importante, ha ayudado a sostener la economía de la isla. Según las últimas cifras, las ganancias provenientes de los servicios médicos –incluida la exportación de personal médico– representaron en 2006, 28% de las exportaciones totales, por una suma de 2.300 millones de dólares. Esto implica beneficios superiores a los obtenidos por las exportaciones de níquel y cobalto e ingresos mayores a los

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Continuing with the answer to our question, we analyze the debate presented by Rollo and Weber (2018), when they mention an article published on April 19, 2017 by the *Folha de S.Paulo* newspaper[56]. Tension, on this topic, is raised about the humanitarian motivations and the economic and political nature of the "export" of doctors by Cuba. The authors, in the same work, highlighted the position of Professor John Kirk[57] in opposition to the *Folha de S.Paulo* article[58]. Kirk observes, in an interview given to the newspaper *Viamundo*, in 2013[59], that the process of solidarity and sending doctors to other countries has been in place for over 50 years in Cuba. He also emphasizes that the country has always invested in the program (in this case, medical diplomacy or the political solidarity program for health). However, in recent times, given the logic of the capitalist world, according to which economic interests determine government actions, it may seem unrealistic to believe in Cuban solidarity. But the solidarity aspect of health missions has always prevailed and still prevails. Thus based on Kirk, the humanitarian principle has not been lost. In the same interview, the professor notes the fact that the island is "more recently using this program as a way to keep the Cuban economy[60] up to date"[61] (Rollo & Weber, 2018).

provenientes del turismo. La exportación de servicios médicos es hoy el negocio más próspero en el horizonte económico de Cuba (Feinsilver, 2008, p. 121).

[56] Translation from Portuguese of: *Folha de S.Paulo*, *"Exportar médicos está se tornando a maior fonte de renda de Cuba"*. Avaliable on https://www1.folha.uol.com.br/paywall/signup.shtml?https://www1.folha.uol.com.br/mundo/2017/04/1876523-exportar-medicos-esta-se-tornando-a-maior-fonte-de-renda-de-cuba.shtml

[57] Professor of Latin American Studies at Dalhousie University in Halifax, Nova Scotia Province, Canada, who on January 19, 2015 sent a letter to the Norwegian Nobel Prize Committee in favor of the Cuban Doctors Internationalism Program as a nomination for the Nobel Prize. Peace.

[58] In a short search on the Google search site for new newspaper articles on this topic, we located one (in Portuguese) on the Voices of the World website, called "Exporting doctors is becoming Cuba's biggest source of income", published and updated in April 2017, in which it is reported that, according to former Cuban Economy Minister José Luis Rodríguez, cited in an article published by the official website Cubadebate, the country's doctors working abroad provided "an estimated value of US$ 11.543 billion on average annually, between 2011 and 2015". The export of doctors exceeds the revenues of the tourist industry, which stood at US$2.8 billion in 2016. Retrieved from http://br.rfi.fr/americas/20170417-exportar-medicos-inclusive-para-o-brazil-ja-e maior-fonte-de-renda-de-cuba-0

[59] Foundation year of the PMM in Brazil

[60] When consultating the SciELO platform combining the descriptors "Cuba", "health", "medical", "solidarity", "export", "economy", (in Portuguese) we did not find any study that uses this debate. In a second attempt, we used the following descriptors: "Cuba", "*Mais Médicos program*", "economy" (in Portuguese). We did not find any scientific article on the relationship between the export of doctors and large-scale financial returns for the Cuban State. Thus, we recognize the importance of a more detailed study on the geopolitical, economic and social dimension of the medical education process in Cuba as a strategic alternative in the relationship between nations.

[61] Translation from Portuguese of: *"mais recentemente utilizando esse programa como forma de manter a economia cubana em dia"* (Rollo & Weber, 2018, p. 24).

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By considering the socioeconomic characteristics of the so-called medical diplomacy and its connection with the curriculum, we direct this analysis to the notion of hybrids. The discourses and the very notion of curriculum, in general, can be considered hybrids (Dussel, 2002). There will be a encounter, in the curriculum, of cultural hybrids, new meanings for old concepts or new concepts, in a mixture of the new, the hybrid and the potential so that new ideas and different perspectives can emerge, which may even question power relations, in the articulation of culture and politics. That is, a result of a process that selects culture and translates it to a particular environment and audience[62] (Matos & Paiva, 2007).

In the case of the curriculum for medicine in Cuba, we agree with those who bring it closer to the theory of human capital (Gomes, Merhy, & Ferla, 2018), with the aim of strengthening the country's potential in education and research in the area of health. Among the guidelines of the studied curriculum, there is a direction for scientific medicine, recognized and built on international terms. Specialized clinics work with more complex levels of care. There is internship for work at the hospital. However, all this is not about making these characteristics the drivers of the process.

We agree with Lopes (2005), when he states that hybridization generates ambivalence, but it is an indicator of the emergence of possibilities along the way for new articulations with social and educational purposes. Finally, the social and humanist role of medicine in the curriculum is guided by comprehensive medicine for the promotion, prevention and rehabilitation of health, where there is considerable space for PHC characteristics.

By recognizing this possible "hybridization" characteristic of the curriculum, the potential of this curriculum in relation to working with integrated medicine is not diminished – an aspect already discussed previously in this article. All of this moves the Cuban medicine curriculum further away from medical training that is centered on a biomedical technical perspective.

The scientific medicine present in the Cuban curriculum recognizes the value of disciplines from an anatomy-clinical medical perspective. The importance of historically constructed scientific/clinical knowledge is present, when the curriculum includes studies such as: anatomy; histology; clinical propaedeutic and semiology; pathologic anatomy; pharmacology,

[62] Translation from Portuguese of: "Ou seja, um resultado de um processo que seleciona a cultura e a traduz a um ambiente e a uma audiência particulares" (Matos & Paiva, 2007, p. 192).

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among others – distributed in the so-called "basic-clinical cycle" and "clinical cycle". The activities in polyclinics and hospitals are distributed along the course and share space with PHC activities. In other words, the hospital and the illness are not the center of the training process (Universidad Ciencias Medica de la Habana, 2015b).

Therefore, we recognize that in this curriculum there is a concern to develop research and monitor scientific advances in the health area. There is also an incentive for research oriented towards integrated medicine, inherent to the meaning of PHC. In the course, there is even the guiding discipline of general comprehensive medicine, taught over ten semesters, and in the professional training period. The internships, in turn, are monitored by the so-called full-time "mentor professors" and during this period learning is distributions into four main modules.

> *Se introduce el Internado Profesionalizante, con cuatro módulos: Atención integral a la familia y la comunidad; Atención integral a la mujer; Atención integral al niño; y Atención integral al adulto … eso permite la formación desde la Atención Primaria de Salud, asumiendo el educando la atención de un consultorio médico, bajo supervisión profesoral*[63] *(Universidad de Ciencias Médicas de la Habana, 2015b, p. 3).*

It is noteworthy that we have not identified paths that lead to a fragmentation of clinical scientific knowledge regarding each medical area covered in the contents, as they are provided with a generalist and humanitarian approach. In the design of the work with PHC, we noticed that care is taken with multiple factors within the community; with the Family; with the individual inserted in a context. Thus, we are saying that in the prescribed curriculum studied (Cuban) we did not identify characteristics such as: an elitist education that prioritizes a white social class (Kemp & Edler, 2004); training focused on the pathophysiology of diseases; fragmentation of the individual into biological systems; doctor-patient relationship in which the patient has a secondary role, according to a logic of power centered on the doctor; a main focus on hospital or pharmaceutical industry; or a strong tendency towards overspecialization

[63] Translation from Spanish of: The Professional Internship is introduced, within four modules: Integrated attention to the family and the community; Comprehensive attention to women; Comprehensive child care; and Comprehensive adult care … this only allows for training from Primary Health Care, taking on the care of a medical consultancy, under professional supervision[63] (Universidad de Ciencias Médicas de la Habana, 2015b).

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(Amoreti, 2005; Provenzano et al., 2014[64]). On the contrary, the analyzed curriculum has, when taken from a general perspective, revolutionary characteristics for health.

Brief considerations...

In this research, the Cuban curriculum seemed to us to be far from wanting to transform health care into a power relationship project. The teaching methodology brings it closer to an area between decolonial pedagogical reasoning and working with health in a comprehensive and humanistic way. Thus, they seek to set up ways of being doctors who are capable of providing assistance and care in different parts of the world, through the revolutionary premise of solidarity and not domination. In a world that follows a primarily capitalist global logic, Cuba acts with another, politicized pedagogical reasoning that links the training of doctors for humanitarian work in missions, with its own value system - therefore, guided by socialist ethics, consistent with the Cuban Revolution.

The way in which the dimension of comprehensive health is present in the curriculum, demonstrates an attempt not to have a strong technological dependence on the hospital. Health care is not limited to the curative nature of illnesses. We sought to learn about the formal curriculum aimed at training Cuban doctors, in order to identify possible explanations for the differentiated performance of these professionals in the PMM. Among the processes and articulations, we identified a proposal for political solidarity and a focus on ethical humanitarian medicine that acts for the comprehensive health of those who receive its care, whether on the island or in other countries. Medicine in Cuba is thought of differently in terms of solidarity and human dignity. Thus, the practice in Brazil was identified with other meanings of care, which had an impact on the assistance provided in the PMM.

[64] The medical training identified in the studied curriculum deviates from the characteristics of the model criticized by the authors of the study called: *A empatia médica e a graduação em medicina. (*Medical empathy and graduation in medicine) Provenzano, B.C. et. al. (2014).

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