"Life as it is" and the development of skills and autonomy in the teaching-service-community integration

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ABSTRACT

Dentistry education aligned with current health demands has been an important topic on the agenda. The objective of this research was to understand the acquired knowledge in supervised internships in terms of the development of skills and autonomy, from the point of view of dentistry students. Qualitative research was used, with two focus groups, with 13 students of both genders, from a dentistry course, from a Federal Educational Institution in Northeastern Brazil. A thematic content analysis was performed. The Collective Health Supervised Internships act as teaching-learning evaluation opportunities, allowing experience in local public health services and territories, creating student awareness of comprehensive care and a broader understanding of the health-disease process. The experiences are always based on the premise that learning is linked to health services and to a path built collectively by everyone. Therefore, the students' understanding of the integration between teaching, service and community allowed the articulation between theory and practice of Collective Health and the development of "socio-logical" competencies involved in the contexts of work in healthcare. With this understanding, the participants recognized the principle of education through/with work and the importance of everyone to exchange and produce knowledge and health education.

Descriptors: Dentistry. Primary Health Care. Teaching.

1 INTRODUCTION

The debate about training in health and its challenges has recently achieved a prominent place on the global agenda of human resources training strategies[1]. This debate is accompanied by great challenges in teaching, mobilizing, and retaining the workforce and its true meaning, nowadays so semantically contested[1,2], the

availability, accessibility, quality, and performance of health actions and services[3]. The health-related targets in the United Nations Sustainable Development Goals[4] also point to the need for this consideration. Among the main challenges is the contextualized training based on the needs of public health systems and, consequently, of the user population[5-7].

Unquestionably, we have trained more health professionals in Brazil, but this alone is not enough[8]. Both public and private dental schools in Brazil have gaps in the definition of competencies for undergraduate education, as evaluated by institutions such as the Global Oral Health Interest Group of Consortium of Universities for Global Health[9,10], which recognizes the gaps in the definition of competencies.

Historically, training in Dentistry has been based on the transmission of technical knowledge and on the psychomotor development of clinical skills, with great emphasis on the disease, distancing itself from the daily routine of public dental health services[6,11-13]. An exuberant, repetitive and inextinguishable 'education by the hands', an '*in vitro* Dentistry', with excess materiality, but deprived of soul and spirit[14], always playing the uncritical game of the odontological-industrial complex that dominates the agendas, interests, and themes of teaching and training.

Internationally, consensus points to the need for early insertion of undergraduate students in community experiences as something to be pursued thoroughly. In search of building community-based dental education[15] the Commission on Dental Accreditation (CODA), in 2013, determined that dental education programs should provide opportunities for students to participate in community service[16]. In Brazil, this insertion is an important axis due to the struggle for the existence and permanent reinvention of the Unified Health System (UHS) and its sanitary reform, and to the fact that it has an essential role to organize health education[6,17-19].

The National Curricular Guidelines (NCG) for Dentistry courses indicate as general competencies: health assistance, decision-making, communication, leadership, administration and management, permanent education, and specific competencies related to Dentistry[20]. In addition, the NCG guides the insertion of students in practice settings of healthcare services, through supervised internships[18,19,21,22]. In this context, the teaching-service-community integration (TSCI) is its best materialized device, although not the only one, the supervised internships in the UHS have an intense vitality, which has a history prior to the creation of the Unified Health System itself and has an imprecise life, sometimes official and nuclear, sometimes peripheral. The TSI reveals an approximative performance between academic training in health and public health policy, its actions and services, workers and users, and their ways of life[18,19,21,22].

However, the literature critically points out that not everything is an internship and not every internship is supervised[6], therefore, the understanding of internship that anchors this research is to enable the student the opportunity not only to insert himself in the public health services in primary care, but also to develop experimentation, elaboration and creation of a certain way of life, a work permanently in progress, in solidary co-construction, even with moments of deep reflective loneliness[6,13,18]. This movement of comings and goings, of advances and retreats, of acceptance and refusal of the restricted clinical Dentistry, aims at the effective knowledge of the UHS by the student, in a space where the experience is in proximity with reality[6].

In this intercultural dialogue of near and distant worlds, of established and non-established knowledge, borders, epistemic barriers, known and foreign lands, there is the organization and establishment of an agenda of great production of intentionalities and competencies. On one side, the knowledge of the academy and, on the other, the services and the community movement of approximations and separations. It is the singular and plural encounter with the other and everything they represent, everything that is identity in a circle-circuit of cultures[18,23].

Faced with this complexity and the scarcity and need for studies on supervised internships in Dentistry from the perspective of students, we present this article with the objective of understanding the meanings of the teaching-service-community integration attributed by dental students participating in supervised internships in the UHS still centered on the Family Health Strategy.

2 METHODS

This is a case study, analytical and qualitative, which explores and describes the perception of students about internships in primary care and thus broadens and deepens the view from their singularities[24].

The study scenario of the research was a federal public institution (FHEI) in Northeastern Brazil. The Dentistry course has a pedagogical project built after the 2002 NCG. In the pedagogical project, supervised internships are practical activities developed in the territories of Family Health Units (FHU) of the city in which the FHEI is located. The objective of the first four supervised internships distributed over the first two years of the course, one per semester, from the first semester on, is the mobilization and availability of opportunities and cognitive resources for the exercise of live work in act, particularly in Dentistry, based on the expanded concept of health and its determinants. Aligned to this perspective, there is an intentionality in the delineation of the formative path performed as a supervised internship, the actions and activities are designed from an idea about the work in health and its implications on people and their life contexts[25].

Each internship analyzed in this article separately includes 30 semester hours and, at the end of two years, 120 hours, always with the direct and full supervision of FHEI professors, and the active participation of preceptors, as professionals from the local FHEI. For each semester, the internship has specific learning goals and as a whole aims at the academic insertion in health services for understanding the work processes in Brazilian primary care, particularly in the Family Health Strategy. Specifically, the supervised internships I, II, III, and IV of the first two years of the Dentistry course are under the responsibility of the professors of the Collective Health area.

Each internship has its own teaching-learning scenario, supervising teacher, preceptor, and a different group of students, varying in number according to the size of the classes involved. The involved fields host an average of 10 to 13 students.

All supervised internship activities are agreed upon and carried out based on the needs of the territory. The planning of field experiences seeks to be dialogical and participatory, providing the involvement of students, in a way that allows students, supervisors, preceptors, workers, dental assistants, and representatives of the social equipment attached to the FHU to participate in the development of work projects. This movement aims to value and legitimize the territory as a learning scenario, subsidizing training guided by compliance with the principles of the UHS and by the health needs of

the population[25].

Actions of health education (dental), collective procedures in Dentistry and health surveillance (dental) are carried out, according to the integration of the oral health team proposed by the National Oral Health Policy (NOHP). The conduction of the teaching-learning-evaluation process of the supervised internships is guided by active methodologies, especially from the problematization of daily life.

For this research, it was selected a FHU that is simultaneously the internship field of the Nursing, Nutrition and Speech Therapy courses, in addition to Dentistry. The preceptors in this unit participated in the editions of the training reorientation programs since 2005, and two of the preceptors are graduates from the Professional Master's Program in Family Health, of the Northeast Network for Training in Family Health.

The School Network has existed in the city for 16 years, and its starting point was the implementation of the Health Education Management of the Municipal Health Department (MHD), which is conducted by a collegiate, with the participation of management representatives, and from several HEIs and technical health schools in the city. The FHEI has an agreement signed with the Health Department, and the students and teachers comply with the Federal Internship Law 11.788, with the signing of internship terms and other bilateral agreements.

In the interval between October 2015 and May 2016, two focus groups (FG) were conducted in person, one with six and the other with seven participants, the first 12 months and the second 18 months after the students' participation in the internships, and lasted an average of 40 minutes. The invitations to participate in the groups were made from a list of students who completed internships II, III and IV at the selected FHU. The focus groups were attended by students of both genders, with an average age of 22.5 years.

Some students at the time of collection were with interrupted registration, and these were excluded. The FG was organized and conducted by a team composed of a moderator with experience in qualitative research, and the functioning of the FG included the participation of two undergraduate students as observers, who recorded aspects of the interaction between participants, and monitored the time[26]. There was a theoretical and methodological alignment on qualitative research with the involved team before the focus groups were conducted.

The FG were guided by a semi-structured script aligned with the goals of the study and held on a day and place more accessible to students in order to allow discussion and interaction among participants considered satisfactory and sufficient for the production of information. The FG were recorded for later transcription and analysis of the information, using Bardin's thematic content analysis method[27]. All the debates were transcribed, eliminating possible elements of individual identification of the participants.

As part of the study's methodology, we also performed a documental analysis of 24 portfolios of the students participating in the research. The portfolio is a tool for monitoring and evaluating the teaching-learning process of the internships. Students are invited to describe their experiences in the field, identifying potentialities and weaknesses in their learning trajectory during the semester. To interpret the data in the portfolios, we also used Bardin's thematic content analysis proposal[27].

The focus groups' transcripts and the portfolios' reports were read and reread exhaustively until the themes were sorted, and the rereading of the material was necessary to

organize the reports and observations. This process was done by three researchers, independently, and later, in meetings to equalize the themes, the analysis categories were defined, based on the adopted theoretical framework and on the recurrence of the reports in the focus groups and portfolios. The records of the focus groups and portfolios were presented without grammatical corrections, and to ensure the participants' anonymity, they were coded with the letters and randomly numbered, "FG" (Focus Group) 1 and 2, and Portfolio 1, 2, 3 ... 24.

The project was evaluated by the Ethics Committee for Research with Human Beings of the Federal University of Paraíba, in accordance with Resolution 466/2012 and the Declaration of Helsinki, and approved with Statement 995.916.

3 RESULTS AND DISCUSSION

From the analysis of the focus groups and the portfolio reports, sets of meanings emerged that provided support for the creation of two categories: "Life as it is": experience and problematization of reality, and Development of competencies and autonomy in the work process.

"Life as it is": experience and problematization of reality

According to the students participating in the research, the supervised internships provided interfaces of contact, familiarity, friction, and strangeness with the UHS, allowing them to build with the other participants an experience-based knowledge, chaining to previous experiences with new meanings, in the direction of the previously established learning objectives, through home visiting. This set of actions was consensual in the second focus group, in the discussion about the fact that "*most of us will enter the UHS and, (...) with the internships, we experience this so that, when we get to the UHS in the future, we have a certain notion of what we will do*". (FG 2). This consensus could be observed in a portfolio as follows: "*we had great experiences in the internship, since, for the first time, we could integrate, in practice, with the community, talk face-to-face with different people through home visits, and get to know the reality of different territories*". *(Portfolio 1)*

It was perceived through the reports how the learning from/in/with reality happened, and how it became an internalized experience. This learning allowed the connection between what was already known and the new, making possible the change, the displacement, and the sliding of meanings and senses[28]. One student recounted that "*in this way we improved a lot our ability to question, plan, and problematize ideas. In addition, our biggest guides in designing the activities have always been the habits and customs in the community*." *(Portfolio 1)*

The TSCI was territorialized in the displacement of students from the university to other learning scenarios. It was a territorialization that presupposes deterritorialization into new territories, when workers had their health units, their work processes, users and territories 'occupied' by young apprentices, turning workers into preceptors and the presence in act in those scenarios[6,18,19,22]. Integration was built as the common, collective, agreed and integrated work of students and teachers of collective health with service workers, managers and service users, aiming at the same time to improve the quality of healthcare, professional training and the development of service workers[17,19,22]. In the following narratives, it is observed how the students understood themselves in this process:

> *"It is quite true that some difficulties were encountered, but I could understand that the improvement of these problems can only happen if there is a co-responsibility between the population and*

> *health professionals to commit to changing practices for the valorization of the system." (Portfolio 24)*
>
> *"It is important to emphasize that, as has already been said, our concern was always to meet the demand of that territory in which we were acting. That is, the themes discussed and the activities carried out were not chosen based on our wishes, but rather based on the needs and the reality proper to that place." (Portfolio 1)*

For the research participants, the FHU is the teaching-learning scenario in which everyone contributes, or is invited to contribute, in some way, to the healthcare practices that take place there, in the stages of creation, preparation and development of the action itself, as well as the analysis, reflection and possible transformation of these actions and activities[6]. Everyone is invited to be a protagonist, proactive and a possible transformer of reality. There is a presence and an invitation for an epistemic rupture, not always accepted, not always successful, but still present, as one student reported in the portfolio:

> *"One of the great lessons left by this internship was the discovery of the importance of the articulation of the health professional with the community, not only in the performance of technical activities, but also and mainly in the performance of social activities that seek to work on health education and prevention." (Portfolio 8)*

Is the TSCI, therefore, an element in itself, instituted and instituting new ways of thinking and doing health education? The answer is yes, because it was not a matter of "colonially and aseptically" transforming the space of actions of the healthcare services and also of the communities involved into extensions or impoverished and precarious reproductions of the hospitals and clinics within the courses[18]. In a post-colonial perspective, it was about building a set of powerful teaching-learning-evaluation actions, which still need further development and possibilities to materialize, but which became, as they were lived, care experiences in real scenarios. In this way, teachers and students became a constituent part of the health services, and the service professionals, now preceptors, assumed co-responsibility in the formation of new generations of Dentistry professionals. There was a consensual sharing of roles in acting in healthcare and in it one student stated that he could "*feel useful to society and understand even more the social responsibility of a true healthcare professional*." *(Portfolio 20).* Another student stated about the same situation that:

> *"All decisions need to be made collectively, according to the priorities discussed by the professionals, always aiming to improve the access and care of users. For this to happen, a good relationship among professionals is fundamental, so that they have their freedom of expression and can gather all the good ideas and transform them into a single thought." (Portfolio 23)*

In the report of one of the students, in the daily life of the services, "life as it is..." happens, and for this reason, they are the "gateway to get to know the UHS", that is, they are sources of significant learning for new knowledge, based on the reality of the FHU and the understanding of the world around them. The veil of the laboratory is removed, of the in vitro world that tries to control the normal conditions of temperature and pressure, that softens the contrasts in halftones of reality. The colors here, where life happens, around and everywhere in the health service, are more raw and closer. There are smells, noises, sounds, because "*in the Internships, we could see*

up close how it worked, that it is really a service where things happen" (FG 1), *since "there is nothing better than reality, life as it is! It is necessary to get out of the gates of the university, out of the books, and learn in practice. (Portfolio 24)*

In this context, much is seen as odd, but many are also the opportunities for problematization for the development of critical and reflective thinking in face of the encountered, seen, and experienced problems. Everything that escapes from the mouth and its teeth, everything that converges in bucality and other possibilities of thought stimulate reflection on the action performed. Having experienced all of these shifts, one student presented in his portfolio reflections that "*we will no longer be the students who are at university with the commitment to just learn and we will become students who contribute to improving, in some way, someone's reality*." *(Portfolio 24)*

The experiences in the territories of the FHU aimed at teaching-service-community integration, based not only on the work process and its semantic extension, but also on its limits, connections, and interruptions. They contributed to an expanded look at another process of illness of the subjects, families, and community, and, in a third key, no less important, contributed to the construction of the bodies and subjects involved, human relations in healthcare, health promotion and education, dialogue, silence, and collective construction with the oral health team[6,18,21]. Other students reported in their portfolios that:

> *"The observation of reality is not only of the health situation of the population, it includes, in fact, also the human resources that one has available, to try to modify this epidemiological situation in the most appropriate and possible way. The attention given to the components located in that area is of fundamental importance for the characterization, subdivision of tasks, determination of functions, and execution of the planned, according to the chosen method." (Portfolio 14)*
>
> *"We know that there has to be a priority of problems and that it must be highlighted to be solved first. With this, a selection of problems must be made, so that they can be further analyzed and solutions found, which will be executed at another time." (Portfolio 21)*

The experiences in the internships were opportunities to bring the 'foreigners' (teachers and students) closer to the 'natives' (health services, their craftsmen, and their work process), as well as the creativity and inventiveness that exists there in the manufacture of care. In this encounter between impressions and realizations, afflictions and affectations, concepts were modified, the UHS and life itself gained more life, and the students experienced future possibilities, remote or near, of working in the UHS with the certainty that, "*when you problematize, you associate practice to theory and it is much more than a transmission of knowledge merely in the classroom*." (FG 1)

The problematization, along with the willingness to know each context and the possibilities of producing health care, are regulatory frameworks that guide the TSCI, the popular health education, and other strategies in the collective health field. We could talk about epidemiologically identifying the causes of the causal factors, but this alone is not enough, despite its great importance; we could dwell on the directives and resolutions of the health policies, but this cannot be all, despite its undeniable importance. There are other ongoing processes, just as relevant or even more so. A critical consciousness of the impotence of part of the tools with which we are trained, and which

are valued almost as the only tool in our training, as the only story of the dental surgeon health professional's performance. A sense of urgency and readiness, an ethos to act towards change, in defense of individual and collective life. By critically reviewing their own practice, the participating students observed new paths of coexistence and autonomous care, permeated by the idea of respect, justice and solidarity[28,29-33].

The planning of the supervised internship activities is participatory, and students, teachers, dentists, and oral health assistants from the Family Health Strategy listen to the community leaders, and the directors of social equipment actively collaborate. In this exchange of ideas, the students realized the importance of developing activities focused on the needs of the population, starting from the local reality, so as to obtain a contextualized planning, with appropriate solutions capable of meeting the demands of that particular service/community. All this led one student to state that

> *"I believe that this was one of the goals of all these internships: that was to make us aware of how to work in a humanized approach, thinking about patients in a complete way, so that we know how to plan activities according to the local reality, aiming at a better quality of life." (Portfolio 12)*

Matching the agendas of HEIs, the MHD, and the community is not an easy or simple task, but it is, to some extent, possible. Behind the agendas, there are people, institutions, more or less articulated healthcare networks; major or minor interests; there are many barriers and, at the same time, the time to build new possibilities[32,33]. In this sense, the municipal health-school system is always in the process of building a history, a past, a present, and everything else that conspires and oscillates, sometimes favorable, sometimes unfavorable to the integration of teaching-service-community.

The question arises around this: who is responsible for the training of new healthcare professionals? Is there exclusivity in this mission? Is it only the universities' role? And is the dilemma of increasing the quality of care in health services only the responsibility of management and healthcare workers? What is the universities' contribution? Exposed to all these questions, one student stated that:

> *"There is the concept that the health service should not be an instrument of appropriation by the university for the training of future professionals, but the teaching-service integration consists of the fact that both institutions should work with the purpose of satisfying the health needs of the population, that is, both work towards a common end. However, the health service has a specific work dynamic, which should not be disturbed by the insertion of students in the service, and it is our responsibility to respect the work processes of the team and seek to understand the social reality in which we will be inserted. And, for this, it is primarily necessary to have the ability to listen." (Portfolio 24)*

In "life as it is", we observe, therefore, the signaling for the formation of professionals who are more and more committed to the people and communities where they have worked, work, and will work, identifying them as they are, their vicissitudes, socioeconomic, epidemiological, and psychosocial peculiarities, without the protective filter of academic distance, where, as a rule, patients only exist when they enter the clinic, never before, and very little after they leave. The real exists and resists being contemplated, captured from a distance, it asks for presence and wandering through its paths and alleys. The realities encountered taught and were

the object of learning, generating reflection, criticism and self-criticism, constituting the fundamental material for the students' personal and professional formation.[6,19-21,29,31].

Development of competencies and autonomy in the health work process

The development of competencies for the dental surgeon requires the continuous practice of complex skills, fundamental for the autonomous exercise of an unsupervised dental practice, aiming at the patient's well-being[20]. The American Dental Education Association (ADEA) has developed a guide with 39 competencies for dental education, which are organized into six domains, namely: 1. critical thinking; 2. professionalism; 3. communication and interpersonal relationships; 4. health promotion; 5. practice management and informatics; 6. patient care, including assessment, diagnosis and treatment planning, and the establishment and maintenance of dental health[34]. However, the development of competencies involved with the contexts, with the demands, and with reality itself[35] requires a set of relational skills or technologies applied to collective life solutions, which requires from everyone involved a set of "socio-logical" skills and abilities, that is, the social logics that act and condition the dental surgeons' cultures of care, and that are submerged in our training for reasons that are beyond the scope of this paper, but can and should be contemplated in other studies.

In this sense, the competencies for the dental surgeon include learning about the field - here understood as the field of health, the intersection of all health professions and other professions - and the core (specific Dentistry knowledge and skills). Field and core here are socially constructed and reconstructed categories, which are sometimes in conflict, sometimes in cooperation. The learning of competencies and responsibilities, in addition to the knowledge, skills, and attitudes proper to these professionals, also goes through the transversal themes that sustain their practice as health workers.

Training dental surgeons and any other health professionals is a mission that does not dismiss the concept of continuous learning, the ability to adapt to change, critical thinking, and the ability to make decisions based on their own assessment. It is the ethical-political formation of a professional who needs to know what to do technically and wants to modify and improve the social reality with the set of its practices. The internships analyzed in this research provided the undergraduates with an existence, a social place of subject-active in the health work process, reflective about themselves and about the health practices they develop or at least create opportunities to do so. The study showed from its studied narratives, the process in which students became analysts of the difficulties encountered and proposers, proponents, to some extent, of solutions to the difficulties as read below:

> *"I realized that I can help change this context from the moment I am aware of these inequalities; I can transform the environment in which I live with actions aimed at the well-being of the collective, which made me think about my great responsibility as a future health professional, to meet the needs of the population." (Portfolio 24)*
>
> *"The most interesting thing was that we would schedule a day and time to bring a certain activity requested by the teacher, however it was up to us exclusively to decide what would be done, in what way, if it would be feasible, if it would reach that target audience, if it would be effective for a certain purpose." (Portfolio 1)*

The students' autonomy is developed in the interdependence between subjects in a process, so that the internships are not isolated, solitary, and inward-looking, because they characterize a teaching-learning practice that is intentionally relational and not independent and/or individualistic. Since they learn from a collaborative perspective, with the participation of professors and UHS workers and mediated by the daily life of the health services, on one hand, the autonomy of the subjects and the group is stimulated, but, on the other, it is acknowledged the external and internal influences of the group itself, of the other FHU workers, of the community, and of the managers. One of the students reported in the portfolio that they could "*feel an active part of the process of transforming the health of the community, as well as I could acquire and transmit knowledge and mainly I could start trying to put into practice the various theories and lessons applied in the classroom." (Portfolio 8)*

The exercise of autonomy has democracy as an essential premise, which, in turn, is at the foundation of the process of transformation of the NCG for health courses. Student autonomy regarding the teaching-learning process is fundamental to expand their possibilities of exercising freedom and confidence in their decision-making at different moments of the process they experience. In the focus groups, two consensus settings were observed around the process of formation with autonomy, the first one about "*you acted like a real dentist, and not like a student, who called the teacher for help. Of course there was the professor's help, but we really thought as dentists" (FG 2)* and the second about *"my resourcefulness that improved a lot, my speech, the way I behave in front of an audience, a group, (...), and this reflects not only here, in Internship, but in other disciplines as well. (FG 1)*

There was consensus on the importance of the protagonism experienced in the internships in the learning process, in which teachers and preceptors acted as facilitators, with educational practices defined and organized by the students themselves, with the interns being the authors, executors, and evaluators of their own learning, but never alone. Professional growth originated in the experience of the practice, autonomously built by the subjects, who recognized, unanimously, that *"in conflicts there were always people who took the lead; this is important, because in every group there are people who have a stronger leadership profile" (FG 2).* This consensus was reported in a portfolio as follows: In other words: *"I developed skills that I didn't even know I had, such as patience to know how to work in a group, administration to split responsibilities, and leadership to take charge of some problems when necessary, besides being able to learn to deal with differences, with distinct realities, to know how to respect the boundaries of others, and to be able to approach and exchange experiences without needing to invade their space, through dialogue or a simple gesture." (Portfolio 8)*

The internships fostered the opportunity to develop skills such as communication, decision-making, collaborative work, conflict management, leadership, and teamwork. The internship experiences were also incorporated, that is, brought into the body in a way that was as valid and validated as the learning within the walls of the HEI. The participants sized up their bodies among the bodies of other subjects and of the community. By placing themselves among and alongside other agents, they deepened their communicative and active listening skills for teamwork. Thus, they expressed that *"learning to work as a team is essential, because if you are*

going to work in the FHS, for sure there are going to be many people who don't think like you, and you are going to have the kind of issues we had in the groups, trying to find a way." (FG 2)
Thus, they also understood that *"We were also able to improve our relationship as a group. We had to learn to listen to different ideas from each other, to speak up when necessary, to mediate conflicts, to work on leadership within each one, and so on" (Portfolio 1)*

> *"About being a "leader", I had no idea how I took the lead and let my leadership spirit shine through, previously unnoticed by me ... it was no easy task, and nothing would have been achieved if we hadn't worked together." (Portfolio 13)*

Learning in a real world, without the filters or shields that academic life inside a university provides, potentiated the integration of the university with its community and the reflexive learning about the difficult and delicate exercise of citizenship and humanized care in a country like Brazil and its urban metropolises[6,22,32,36]. In a possible faculty portfolio we would put art and life together to illustrate what the students have tried to tell us about:

> *"And I've learned that one always depends on so many, many, different people.*
> *Every person is always the mark of the daily lessons of so many other people, and it is so beautiful when we understand, that we are so many people wherever we go*
> *It is so beautiful when we feel that we are never alone, no matter how much we think we are.*
> *It is so beautiful when we step firmly on these lines that are in the palms of our hands, it is so beautiful when we go to life, on the paths where the heart beats much more strongly. (Gonzaguinha, "Caminhos do coração")*

The limitations of the study are related to the very nature of qualitative research that took place in a particular setting and with a group of students. Thus, it would be interesting to use other data collection tools and other types of studies. It is noteworthy that the portfolios were produced by the students in the context of follow-up/assessment, so the students may have filtered out some information.

4 CONCLUSION

The focus groups revealed in depth the dental students' formative path from their impressions about what they experienced in the territory, and the portfolios allowed us to identify the incorporations or the records in their bodies and minds, experienced by exposure to the integration developed in the supervised internships.

We conclude that these internships in public health have acted as teaching-learning-evaluation opportunities outside the university walls, allowing, with their experiences in public healthcare services, a more sensitive approach to life lived where they are not used to going, to integral care, and to a broader understanding of the health-disease-care process.

The learning linked to health services and built collectively provided, therefore, the students' understanding of the need for integration between teaching, service, and community, and the potential for innovation that this system brings, allowing the articulation between theory and practice of Collective Dental Health and the development of "socio-logical" competencies involved in the contexts of health work. With this understanding, the participants recognized the principle of education through/with work for health and the defense of

life and the UHS, and the importance of everyone for the exchange and production of information and knowledge in health.

RESUMO

"A vida como ela é" e o desenvolvimento de competências e autonomia na integração ensino-serviço-comunidade

A formação em Odontologia alinhada às demandas atuais de saúde tem sido uma agenda importante. O objetivo desta pesquisa foi compreender os aprendizados a partir dos estágios supervisionados na perspectiva do desenvolvimento de competências e autonomia, a partir da voz de estudantes de Odontologia. Utilizou-se pesquisa qualitativa, com dois grupos focais, com 13 estudantes, de ambos os sexos, de um curso de Odontologia, de uma instituição federal de ensino no Nordeste do Brasil. Procedeu-se à análise temática de conteúdo. Os Estágios Supervisionados da Saúde Coletiva atuam como oportunidades de ensino-aprendizagem avaliação, permitindo vivência nos serviços públicos de saúde locais e territórios, sensibilizando o estudante para o cuidado integral e para a compreensão ampliada do processo saúde-doença. As vivências partem sempre da premissa de que o aprendizado está vinculado aos serviços de saúde e a um percurso construído coletivamente por todos. Portanto, a compreensão dos estudantes sobre a integração entre o ensino, o serviço e a comunidade, permitiram a articulação entre a teoria e a prática da Saúde Coletiva e o desenvolvimento de competências "socio-lógicas" implicadas aos contextos do trabalho em saúde. Com esse entendimento, os participantes reconheceram o princípio da educação pelo/com o trabalho e a importância de todos para troca e produção de conhecimentos e de saberes em saúde.

Descritores: Odontologia. Atenção Básica. Ensino.

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