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Family Medicine Education in Brazil: Challenges, Opportunities, and Innovations

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Abstract

Since 1988, Brazil's public health system has tried to build a national health system that responds to the needs and expectations of Brazil's population. In 1994, the government created the Family Health Program to help carry out that goal. However, the dearth of family physicians in Brazil—the central figures in that program—limits the program's effectiveness. The lack of family physicians can be traced primarily to the medical schools, which at that time were not training such physicians. This, in turn, can be traced to a number of conditions in Brazil (e.g., the bias toward specialization in both medical education and care) that favor specialists and discourage generalists.

In 1992, a group of physicians founded an academic society in São Paulo to promote the humanistic dimensions of doctoring and "establish the proper basis and scientific methodology for family medicine." The society's board eventually began teaching humanistic medicine to medical students, who became interested in family medicine. The board realized that its mission should expand to find ways to introduce and integrate family medicine into the medical schools of Brazil, to establish family medicine's academic credentials, help attract students to family medicine as a career, and secure family medicine's credibility in the marketplace. Since that time, the society has developed a variety of initiatives involving students, faculty, and medical schools to pursue these goals. The authors describe these initiatives, the progress made, and the challenges ahead.

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In this article, we describe the discouraging climate for family medicine in Brazil and how, over the past 16 years, a group of doctors, working with students, residents, medical schools, and others, is changing that climate.

Introduction: The Brazilian Scenario

In 1988, the Federal Constitution of Brazil gave all Brazilian citizens the right to access preventive and health-promotion services. To help implement that right, Brazil's public health system (Sistema Unico de Saúde, or SUS) represents the consolidation of an effort to build a health system that responds to the needs and expectations of Brazil's population. With the establishment of SUS, it became the responsibility of the medical schools and universities to prepare professionals capable of delivering the kind of health care envisioned by the SUS.

In 1994, the Brazilian government continued the same health strategy and launched the Family Health Program (Programa de Saúde da Família, or PSF), envisioning the creation of professional health teams that would each become responsible for the health care of 3,000 people. The implementation of the PSF, inspired by functioning models in other countries, has progressed, and there has been regular growth in the number of these "family health teams."[1] However, the dearth of family physicians in Brazil, arguably the central figures of the health teams, is the factor that limits the effectiveness of the PSF program.

After 20 years of a functioning SUS, it is now clear that the universities and Brazil's 170 medical schools—primarily the latter—are not preparing the kinds of physicians who can foster prevention and health promotion by providing the basic health care that the SUS requires. To the contrary, the focus of their professional training is on illness in the hospital and on specialization in which care is increasingly dependent on medical technology. Thus, the PSF is confronted with the problem that physicians with the appropriate skills, attitudes, and knowledge are not being graduated by the medical schools. For both the SUS and the PSF, there is a mismatch between the health strategies promoted by the government and the types of physicians being produced by the medical education system.

Because of the government's strong desire to encourage family health care by implementing the PSF, it has encouraged and funded the establishment of residency programs in family medicine in a number of medical schools. Even these programs, however, are poorly subscribed and are not popular with medical school graduates, receiving far fewer applications than do any other specialty. This is because the timid response of the medical schools has led to programs that are poorly defined, devoid of academic methodology, and, thus, clearly at a disadvantage compared with the other specialty and/or postgraduate programs that have been offered to recent medical graduates. The absence of an academic component in Brazil's family medicine education translates into a lack of credibility and sparks little interest in the young professionals.

Because the PSF is the centerpiece of the government's health program, it has the

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resources to offer jobs with attractive remuneration. But even this is not enough to regularly attract young medical graduates, particularly those with other options. In addition to a reasonable job offer with adequate salary, the program needs to seriously address the development of a specialty in family medicine that has the academic and scientific credibility to motivate medical graduates to choose lifelong careers in family medicine.

Such development will not be easy. To establish family medicine as a specialty that is taken seriously, the universities and medical schools must recognize and design it as an academic discipline. Despite the fact that there are some family medicine residency programs in Brazil, in the medical schools family medicine is, with a few exceptions, not taught, and family medicine faculty are absent in academic settings. This lack of family medicine in undergraduate medical education curricula is the fundamental reason that it is so difficult to promote family medicine to students and encourage them to choose family medicine as a career.

The problem stated above is not unique to Brazil's medical education system. In several other Latin American countries, there are virtually no family medicine departments in medical schools and no family physicians teaching its principles. By virtue of this, in Latin America it is more necessary than ever to reform the educational approach to family medicine. The example of other countries that have created associations of family medicine professors (see www.stfm.org) as a strategy of academic implementation offers those of us in Brazil and elsewhere who wish to foster family medicine a starting point to think about the reconstruction of our specialty.

The Inhospitable Climate for Generalists in Brazil

Health care in Brazil, both public and private, emphasizes the specialties in which the human being is seen in a fragmented way. In this context, technological advances are valued, to the detriment of humanistic dimensions. At the same time that doctors are compelled to choose careers in such specialties, they realize that something is missing. Doctors and patients are unsatisfied, and the costs of medicine and care are becoming unsupportable. Yet family medicine, which emphasizes the humanistic dimension, is not recognized as a true specialty and is little known by patients and doctors in general.

More than 50% of Brazil's medical graduates are unable to find a residency program to complete their specialist training. Another avenue toward specialization is available, however, and many of these physicians pursue and acquire specialization through continuing medical education courses and professional practice in a particular specialty, eventually gaining certification from the medical society in their chosen specialty. Thus, even when they are unable to enter a residency, medical graduates see a specialty as necessary to validate their professional competence and standing.

Given this situation, who are the generalist physicians who actually practice in Brazil? If the majority of the students long to become specialists (because that goal is what they see, live, and breathe in the medical schools), who would want to become a generalist? Although a minority of those practicing general medicine do so by choice because of their commitment to the discipline, it is clear that the majority who practice general medicine do so because, for a variety of reasons, they were unable to specialize. Besides that, there are few, if any, programs of continuing education in generalist areas, there is little planning for certification that truly evaluates and validates the quality of generalist professionals, and, finally, there is no real commitment from the medical schools, which place the generalist physician at serious risk of becoming a second-rate professional. Thus, the contradiction mentioned earlier: the nation seeks to make access to health care a right for every citizen, but it is not training the high-quality generalist physicians needed to provide that care.

A particular issue concerns the nature of internal medicine (called *clinica medica,* or clinical medicine) in Brazil. The departments of internal medicine are well established in the academy and might consider that their function is to prepare physicians for competency in primary care, including competency in family medicine. Indeed, there have been some efforts to (minimally) decrease hospital-based care and increase ambulatory care (although rarely continuity of care) in internal medicine residencies. However, because of the influence of the marketplace, more is not done. In practice, with rare exceptions, those who teach internal medicine in the universities are "generalists" only as a complement to the practice of a specialty. It is rare to find medical educators who present themselves as general internists; instead, they present themselves as cardiologists, pulmonologists, gastroenterologists, etc., who also practice internal medicine. Because this is the model that students see, it is natural for them to conclude that the proper professional choice is to follow the same path trod by the masters.

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Ways to Empower Family Medicine

Gaining credibility in medical schools

Family medicine has been a defined specialty in many countries for more than 40 years, although the academic incorporation in medical schools has varied among countries, and even within a single country. Despite the variety, two conclusions are clear to us. First, the credibility of family medicine as a specialty for medical students is related in significant part to its degree of academic incorporation. The presence of the specialty in the medical school allows transmission of the specialty's values, confers on it the credibility it is due, and allows a practice—clinical and educational—of the new paradigms proposed.[2] Second, the impact of family medicine, when well-trained physicians are at the core of a health system, makes a positive difference in the effectiveness of a primary-care-oriented health care program.[3]

Thus, it is important to understand the academic role of the generalist, in which the family physician makes the difference.[4] The needs of patients, especially those with chronic illnesses and multiple comorbidities, require a professional who can approach those problems with a broad perspective and who adopts a more inclusive vision to guide his or her methodology of care. Family physicians offer more than a simple sum of solutions to their patient's diverse health problems, because they realize that confronting those problems is much more complex than solving an algebra equation. Instead, such a physician brings a new perspective, a different gestalt, a wider

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vision to face patients and their needs. This new paradigm must be built, learned, and taught.

Our experience makes clear to us that the acceptance of family-medicine-as-a-specialty progresses as family medicine is gradually accepted within the medical school as an academic discipline; this is the crucial process that is only beginning to happen in Brazil. When there are excellent family medicine curricula for both students and residents, it becomes possible to attract students—future physicians—to this specialty. Role models are also important; family physicians who possess academic respectability and who teach primary care practice with resolve and competence can awaken a sense of vocation in their students. In addition, we maintain that a greater presence of family medicine in the academic setting will evoke emergent leadership among students, winning them prestige among their teachers. Finally, once a proper place is reached in the academy, family medicine will play an important role in continuing education for all who practice primary care, helping maintain the quality of those professionals' work and improving the certification processes.

Gaining credibility in the marketplace

If family medicine graduates are to have employment, their work must gain credibility in the marketplace. The private health insurance that is available to some patients in Brazil (about 30% of the population) is an opportunity and marketplace for family medicine. Medical and insurance agencies search for quality services, health services must be managed in a rational manner to reduce costs, and patients want their own personal physician. The convergence of these factors places the family physician in a leading role. This opportunity also challenges family medicine to demonstrate that family physicians are skilled, provide quality care, and can be effective personal physicians and health managers.

Family medicine physicians in Brazil now have a valuable opportunity in the country's private medicine sector to develop service-provision projects jointly with health insurance companies and private companies. The quest for quality services by these companies and the need for physicians who can expertly coordinate and manage health services, satisfy the patient who desires a personal physician, solve problems, and contain costs opens a promising working field for family physicians. But, to realize this opportunity, family medicine education must be much more emphasized and embedded in Brazil's curricula for students and residents.

How an Academic Society Is Fostering Family Medicine in Brazil

SOBRAMFA, which stands for *Sociedade Brasileira de Medicina de Família* (Brazilian Society of Family Medicine), is an academic society founded in 1992 in São Paulo, Brazil, by a group of doctors (including P.G.B.), most of them specialists, and some faculty from several medical schools in the same city. The initial aim of this group was to promote the humanistic dimensions of doctoring and to establish the proper basis and scientific methodology for family practice. It was an exciting experience to start talking about humanistic doctoring, although at that time those of us who were involved in establishing SOBRAMFA thought of this mainly as a particular style that all doctors should have in their practices. In 1993, SOBRAMFA established a department at the São Paulo Medical Association and had monthly meetings. Several doctors came and felt comfortable with the department's humanistic aims, but they had little time to devote to SOBRAMFA because they were busy specialists dealing with their own practices.

In 1995, some of the directors of SOBRAMFA's board returned to academia and started teaching medical students in disciplines related to humanistic doctoring, such as psychosomatic medicine, anthropology, and medical ethics. The students became interested in the concept of family medicine—mainly, the humanistic approach the SOBRAMFA physicians were talking about—and they started the student branch of SOBRAMFA. SOBRAMFA's board realized that its mission was not only to teach medical students but also to find paths to introduce and integrate family medicine into the medical schools of Brazil. In both these ways, the society could promote family medicine as a vocation for our country's future doctors.

During the past 16 years (1992–2008), SOBRAMFA has spread the family medicine philosophy among medical students through congresses, academic meetings, family medicine seminars, international meetings set in Brazil, and continuing medical education courses. By now, the academic division of SOBRAMFA (students' branch) is represented in several different medical schools. The students interested in family medicine are becoming real leaders in their own medical schools. Students' interest is a powerful resource to increase recognition of the core values of family medicine, as students realize they need these values to become better doctors and, in greater numbers, are becoming interested in family medicine as their future specialty choice. Students are able to organize and promote family medicine among their peers, through interested groups, meetings, and congresses.

During this 16-year period, almost 3,000 (mostly Brazilian) students have been involved in some of the activities promoted by SOBRAMFA. Family medicine interest groups were created in eight medical schools in São Paulo State, and students from 10 other medical schools came to SOBRAMFA's meetings. SOBRAMFA runs an academic project called PRAMEF-21 (in English, *Academic project for the 21st-century family doctor*), a clinic where students from five different medical schools see patients from the community, learn the skills and methodology of patient-centered medicine, and share with their peers their experiences in learning, using the reflective-practice approach. Also, the monthly meetings of the family medicine committee of the São Paulo Medical Association, which are largely devoted to continuing medical education on a topic chosen each year, are led by the students. This is an innovative learning model: students teaching students within a continuing medical education course. The annual family medicine academic meeting, attended by all interested faculty and students from Brazil's medical schools (which, by 2007, had been held every year for 11 years) is organized by students working with SOBRAMFA. For the enthusiastic individuals who attend, these meetings offer a valuable environment for learning. All SOBRAMFA activities are set in São Paulo, a city of 17 million people with 10 medical schools in the metropolitan area, which means that more than 5,000

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medical students have easy access to those activities.

SOBRAMFA, which is an academic, nonprofit organization, devotes its resources to academic projects (such as PRAMEF-21 meetings and student courses) and to promoting family medicine among medical students. The SOBRAMFA board members and young doctors engage in a variety of settings and activities, including practicing in outpatient office settings, making home visits, managing patients with chronic illnesses, participating in hospital rounds, giving palliative care in nursing home settings for geriatric patients, promoting women's health, and making preoperative evaluations. In all of these activities, the family physicians provide continuity of care to patients with multiple comorbidities. In other words, whereas SOBRAMFA promotes the academic perspective of family medicine, the physicians involved in it put this perspective into practice, providing medical care in a great variety of scenarios and being paid mainly by private health care companies, hospitals, and insurance corporations. This is an important way to show both the new paradigm of care provided by family doctors and the excellence of that care as the health market searches for models of quality care.

Within the last seven years, the directors of SOBRAMFA have come mainly from the group of young physicians who, as medical students, were interested in this new academic and educational project and helped establish the academic activities of family medicine in their schools.

And what about the students (almost 3,000) who have come to SOBRAMFA meetings and other activities since it was founded? Although most of them chose other specialties, they respect and value what they learned in SOBRAMFA activities—mainly, the humanistic perspective of doctoring. A small group of these students (up to 3%) have entered family medicine residencies of the PSF program. Many of this latter group of former students keep contact with SOBRAMFA through academic meetings. Our impression is that most of them don't seem to be happy with their positions and/or practices; they often acknowledge that they chose the PSF residencies because these residencies offer more security. They miss the SOBRAMFA-inspired approach to family medicine they learned when they were students. And they often find themselves working without supervision.

Pondering the results of the society's work during the last 16 years has helped those of us who are involved with SOBRAMFA to create its current projects, discussed in the next section. We understand that it is not enough to encourage students and excite them with a new perspective of doctoring. In addition, a proper strategy is needed to offer them new ways to put into practice what they have learned. The learning period should not just become like a lost dream once the medical student has graduated. Instead, it must be real training for the student's future work. What SOBRAMFA has been trying to impress on those students is that if they discover that family medicine is their passion, they can find ways, through the SOBRAMFA projects and beyond, to become fine private practitioners and family medicine teachers and to help spread the model of family medicine throughout Brazil.

Securing the Future of Family Medicine in Brazil

In recent years, family medicine leaders and educators have discussed the future of the specialty, mainly in the United States, and have provided thoughtful guidelines for the construction of the discipline.[5] The development of family medicine and its identity as a discipline have been grounded in the core values of continuing, comprehensive, compassionate, and personal care provided within the context of family and community. These core values are responsible for much that the public currently respects and trusts in family physicians. They have shaped the identity of individual family physicians and have helped establish a legitimate position for such physicians in academia and the larger medical community. All family physicians worthy of the name share a common commitment to provide or coordinate all care specified in the family physician's basket of services, thereby serving as effective personal "medical homes" for their patients. That is, a family physician serves as the focal point through which all individuals receive a array of acute, chronic, and preventive medical care services.

The current president of the Society of Teachers of Family Medicine makes useful comments in his monthly column[6] about the future of family medicine, and he stresses that the focus on core skills and performance in the discipline resonates with empirical studies' findings of a similar focus in visionary organizations.[7] Those of us who are family physicians know that our clinical practices are our most influential teaching venues, and that the lessons embedded in the clinical sites can reinforce our teaching in traditional classroom settings. Unfortunately, they can, instead, subvert and negate that teaching, because the clinical site is part of the "hidden," or unintentional, curriculum, whose power is well recognized. Nevertheless, the experiences that the society's president describes make clear that for those medical students who became family medicine leaders, it was not the classroom teaching but, instead, the positive experience in the clinical setting, that made the difference.

The SOBRAMFA board assumes that *teaching while practicing* is the best way to help create family medicine leaders among interested medical students, foster their continuous formation in that discipline as they proceed through medical school, and help them develop their scientific competencies. The practice must be in the real world—the "real market" for the young doctors, the field they will soon enter and in which they will attempt to obtain positions. Thus, SOBRAMFA's current projects, described below, are guided by the teaching-while-practicing paradigm and are oriented to ensuring the future of family medicine in Brazil, in accord with the recommendations of the Future of Family Medicine Report of the Society of Teachers of Family Medicine (www.stfm.org/ffm/index.htm).[8]

Sparking interest in family medicine among medical students: The Mini-Fellowship in Family Medicine Program

One of SOBRAMFA's main aims is to spark students' interest in family medicine as a career by exposing them to the discipline's values and practice.[9] This exposure occurs mainly in the Mini-Fellowship in Family Medicine (MF2) program, a one-week elective clerkship for Brazilian medical students. Students experience family medicine by seeing

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patients under the supervision of SOBRAMFA faculty and residents in a range of practice settings. Many of these learning activities occur in SOBRAMFA's urban, private-practice ambulatory clinics, but students also see continuity patients with comorbidities in home visits, inpatient hospital rounds, and palliative care and nursing home settings for geriatric patients. This structure is not available to medical students in any of their medical schools, but it is easily incorporated into the practices of SOBRAMFA's doctors and residents, who provide care in all of these settings.

At this writing (2007), more than 100 students from 30 different Brazilian medical schools have completed the MF2 experience. On the last day of the MF2, students evaluate the program and themselves. After each student completes a self-evaluation form, SOBRAMFA's faculty or residents lead a group discussion about such topics as the program's strengths and needs and the students' perspectives on their lives as future physicians. Students report that they experienced the reality of family medicine, saw "real family physicians working," learned about the philosophy of family medicine, engaged in reflective practice, and worked with a positive and productive team. A collateral outcome of the MF2 program is that SOBRAMFA's residents, by working with the students, can hone their teaching abilities and become more aware of educational issues.

Sparking interest in family medicine among new residents: The Fitness Program

The Fitness Program (FP),[10] which is short for the Portuguese equivalent of *integral formation and training in service with supervision*, is an innovative family medicine residency founded by SOBRAMFA in 2003. This program's hallmarks are continuity and excellence of care.

A description of the way residents are selected in Brazil, which is different from the approach in the United States, is beyond the scope of this article. It is sufficient to say that applicants to the FP participate in a required one-week (40 hours) family medicine rotation similar to the MF2 program. The selection process differ in that the FP's objective is to clarify for the candidates what family medicine is so that they can make more informed career choices. Excellence in medical practice, the family physician's roles as a teacher and leader, and teamwork are emphasized in this rotation. At the end of the rotation, each applicant interviews with faculty and residents before the selection committee decides whether to offer an FP residency position.

During the three-year FP, faculty supervise residents to hone the residents' clinical decision-making skills, evaluate them, and suggest ways they can develop personally and professionally. To accomplish the program's goals, faculty follow the residents' practice in different clinical settings. The faculty become the residents' role models in an approach similar to that of the master–apprentice relationship of the Middle Ages.

When specialty-based instruction is necessary, the specialist faculty come to SOBRAMFA's clinic to teach. SOBRAMFA established this approach because its own faculty believe that the learning focus shifts away from patient-centered care when the FP residents train in specialty environments. Sustaining learning within the family medicine context about the diseases that are prevalent in primary care is an excellent outcome in this training.

Settings for learning and practice include home visits, ambulatory clinics, long-term care facilities, and hospitals. Residents learn about many areas of care, including chronic patient management, palliative care, women's health, and preoperative evaluation. Ongoing educational activities enhance learning and provide a collaborative environment that facilitates application and teamwork to help graduates become family physicians, teachers, thinkers, and leaders.

The main outcomes of the FP, identified from the residents' evaluations, include improved doctoring, teaching, and leadership skills and enhanced reflective practice. The program helps the residents improve their individual strengths, identify and address their needs, and polish their teaching and leadership skills. The medical students in the MF2 program report how enjoyable it is to learn from the FP residents and observe medical care that mirrors family medicine's core values. The FP is a unique way of developing excellent physicians, teachers, and leaders for Brazilian patients and to guarantee the future of family medicine in our country.[8]

Sharing the Brazilian experience: The International Fitness Program

The International Family Medicine Fellowship (also called the International Fitness Program, or IFP) is one of SOBRAMFA's continuing medical education programs. IFP is for family medicine residents, medical students, physicians, and other primary care professionals from countries outside Brazil. The IFP allows SOBFRAMFA to share the Brazilian experience in developing family medicine and promoting leadership, with a focus on Latin America to improve health for patients and the community, which is the goal of the international "Health for All" proposal of the World Health Organization, formulated at Alma-Ata in 1978.

The IFP ranges from four to eight weeks, with the objectives of (1) teaching about family medicine as an academic discipline, (2) developing research concerning the family physician's daily practice activities and publishing the findings, (3) teaching participants information-mastery skills, how to keep up with the scientific literature, and medical decision making in practice, and (4) leadership development. The main activities in the IFP are home visits, patient care in free clinics, palliative care, and geriatric care. Also, scientific meetings at SOBRAMFA are held, in which information mastery is developed for learning to search for medical information and apply it. Medical education research is also promoted. IFP participants report that they have learned a variety of relevant topics, such as caring for the whole patient, the humanistic perspective of family medicine, maintaining the passion for idealism in medicine, and the SOBRAMFA team's collaborative approach that integrates participants into a comfortable multicultural environment.

To select applicants and develop the program objectives and activities, SOBRAMFA created its International Consultant Committee (ICC), composed of family medicine leaders from several different countries. Among their duties, the ICC members write recommendation letters for highly qualified candidates

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(e.g., practicing physicians, residents, and medical students) for the IFP.

The IFP has led to the forming of the Pan American Association for Academic Family Medicine (APAMEFA) in 2005. This society's principal objectives are to develop and strengthen family medicine as an academic discipline in the Americas and to promote an international exchange program for family medicine faculty, residents, and students. APAMEFA seeks (1) to identify and develop leaders who foster progress in family medicine in their respective countries and (2) to promote diffusion of family medicine knowledge and values.[11]

Educational innovations to foster the future of family medicine in Brazil

Showing students family medicine's person-centered perspective on medical care. SOBRAMFA shows students that family medicine has a new (yet ancient) perspective on the art of medical care, one that focuses on the person. This model of care permeates the teaching and thinking of the family physician. The medical student becomes an important collaborator in the patient's care, which influences the student's development as a future physician. Students learn that family physicians look at patients as people instead of as their disorders, because the needs of the patient guide the physician's medical caregiving. In addition, both the health management education that SOBRAMFA's programs offer and the variety of patient presentations that students experience promote their learning and motivate them.

SOBRAMFA actively recruits students who show promise as future leaders in family medicine, presents them viable career paths that merge professional choices with stimulating challenges, and trains them to teach so that they can prepare for their future faculty roles. Requiring students to interact with family physicians in various practice settings and to better understand the family medicine paradigm by leading theoretical discussions of it have produced two types of learning. First, students learn to integrate their theoretical knowledge with the practical issues of actual patient care. Second, students see their family physician teacher as a colleague who constantly searches for current information to apply in patient care.

Educating physicians who can balance the technological and humanistic aspects of care. Doctors live in two worlds.[12] One consists of powerful technology, rationality, and ever-increasing numbers of scientific discoveries. The other world, which is less clearly defined, includes feelings, values, and the context of illness in patients' life experiences. Medical education must attend to both worlds, helping students to address their doubts and expectations and to build technical and humanistic skills. In its training of future physicians to balance the technological and the humanistic, SOBRAMFA balances the educational process with technological information and humanistic knowledge. Teaching humanism is not an anachronism, and it is made current and vital using both traditional approaches (literature, opera, etc.) and modern ones (films, modern music, the Internet, etc.). Humanism and modern technological advancements are both considered crucial to the education of SOBRAMFA's students; striving for the balance between them is something that is often not done in Brazil's medical school settings.[13]

Teaching to instill in students the permanent habit of reflection is at the heart of SOBRAMFA's philosophy of family medicine. To stimulate reflection, SOBRAMFA has developed innovative methods to address the students' affective education by using movies, opera, and literature in medical education.[14–16]

Teaching Appropriate Attitudes of Care: The Core Mission of Family Medicine Education

To SOBRAMFA, helping students understand and internalize the type of care we provide—teaching them "the family medicine attitude" toward care—is our most challenging issue. Although some may say that an attitude cannot easily be taught to others, our experience and the findings of family medicine researchers say otherwise.[17] We can teach medical students how to care for patients while modeling values we embrace.[18] The family medicine learning environment promoted by SOBRAMFA fits well with students' inquisitive attitudes, because faculty are readily available to students in actual patient-care situations to model the behaviors of family physicians as they care for individual patients. Students are exposed to actual case management, telephone consults, patients in their homes, and the excitement, uncertainty, and rewards of emergent medical care (the opposite of "cookbook" care, where one size fits all). Students also discover that the physician's knowledge of patients' individuality becomes a diagnostic resource. Knowing patients and their values, needs, and particular medical conditions helps the doctor learn each patient's personal version of the disease and, thus, provide appropriate care.

Students live these learning experiences in real time, in real situations. Working with these students over the years, our experience has been that despite all the complications, difficulties, and, sometimes, failures that attend patient care, our students become more committed to such care. Their enthusiasm and consequent choice of family medicine careers are the foundation of the academic credibility and marketplace viability that SOBRAMFA is seeking to bring to family medicine in Brazil. We call on others to join us in this endeavor.

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Did You Know?

In 1889, researchers at Johns Hopkins University introduced the rubber glove for use during surgery.

For other important milestones in medical knowledge and practice credited to academic medical centers, visit the "Discoveries and Innovations in Patient Care and Research Database" at (www.aamc.org/innovations).

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