RBEM
Revista Brasileira de Educação Médica

ORIGINAL ARTICLE

DOI: https://doi.org/10.1590/1981-5271v45.3-20210023.ING

Clinical communication in medical practice internship: articulating the skill to an integrated and competence-oriented curriculum

Comunicação clínica no internato: habilidade em interface com o currículo integrado e orientado por competência

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ABSTRACT

Introduction: Clinical Communication is an instrument for interaction between professionals and between them and users, being extremely important to ensure integral care. The complexity of the users' biopsychosocial demands must be understood and worked through skills developed beyond the technical and biomedical knowledge, including a more extensive training in relation to the human being. In the curriculum of a medical school institution in the interior of São Paulo, Clinical Communication is a skill expected of the student in all undergraduate scenarios. During medical internship, it is important that communication practice be developed in an integrated fashion, considering the biopsychosocial aspects of the subject under care; however, the literature demonstrates that this skill is superficially explored in training, causing difficulty for its effectiveness. Thus, it can be assumed that there are different understandings about the concept of Clinical Communication and its theoretical-practical articulation between teachers and students, being necessary to analyze this educational process during internship.

Objective: Thus, the objective was to question how teachers and students from a medical course internship understand the teaching-learning aspects about Clinical Communication in an integrated and competence-based curriculum.

Method: This was a qualitative study, which included eleven 5th-year medical students, twelve 6th-year medical students and nine internship teachers. The interviews were semi-directed and carried out based on an interview script, which were later transcribed and submitted to the analysis of content, thematic modality.

Results: Three categories emerged from the concepts and characteristics of the topics "Clinical Communication" and "Curriculum": 1) What involves clinical communication; 2) Development of clinical communication during the undergraduate course and 3) Proposals for the training of internship students and teachers. It was observed that the participants understood the concept of Clinical Communication and its importance for the students' training, but also that it is difficult to develop this training due to the lack of knowledge about the curriculum, student work overload and teacher devaluation.

Conclusion: The study considers the development of Clinical Communication skills of internship students and the possibilities for reflection on gaps mentioned by students and teachers.

Keywords: Health Communication; Faculty; Medical Education; Medical Students; Internship and Residency.

RESUMO

Introdução: *A comunicação clínica é um instrumento de interação entre profissionais e destes com os usuários, importantíssimo para assegurar o cuidado integral dos indivíduos. A complexidade das demandas biopsicossociais dos usuários deve ser compreendida e trabalhada por meio de habilidades desenvolvidas para além do conhecimento técnico e biomédico, com formação mais ampliada em relação ao ser humano. No currículo de uma instituição de ensino superior do interior paulista, a comunicação clínica é competência esperada do estudante em todos os cenários da graduação. No internato médico, em especial, é importante que a prática da comunicação seja trabalhada integradamente, considerando os aspectos biopsicossociais do sujeito relacionados ao cuidado; todavia, a literatura demonstra que essa habilidade é explorada superficialmente na formação, acarretando dificuldade de sua efetivação. Desse modo, parte-se do pressuposto de que há diferentes compreensões acerca do conceito de comunicação clínica e de sua articulação teórico-prática entre docentes e discentes, sendo preciso analisar a formação no internato acerca destes.*

Objetivo: *Assim, objetivou-se questionar como professores e estudantes do internato de um curso médico compreendem o processo de ensino-aprendizagem acerca da comunicação clínica em um currículo integrado e orientado por competência na matriz dialógica.*

Método: *Trata-se de um estudo qualitativo que contou com a participação de 11 estudantes da quinta série, 12 estudantes da sexta série e nove professores do internato. As entrevistas foram semidirigidas e realizadas a partir de um roteiro de entrevista, sendo posteriormente transcritas e submetidas à análise de conteúdo, modalidade temática.*

Resultado: *Três categorias emergiram do conjunto de concepções e características dos temas comunicação clínica e currículo: 1. "O que envolve a comunicação clínica", 2. "Desenvolvimento da comunicação clínica na graduação" e 3. "Proposições para a formação de estudantes e professores no internato". Pôde-se observar o entendimento acerca do conceito de comunicação clínica e sua importância na formação dos estudantes, porém evidenciou-se dificuldade de desenvolvimento na formação devido ao desconhecimento do currículo, sobrecarga discente e desvalorização docente.*

Conclusão: *O estudo contempla a comunicação clínica no internato e possibilidades de reflexão acerca de lacunas citadas pelos estudantes e professores.*

Palavras-chave: *Comunicação em Saúde; Docentes; Educação Médica; Estudantes de Medicina; Internato e Residência.*

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Chief Editor: Rosiane Viana Zuza Diniz. | Associate Editor: Roberto Zonato Esteves.

Received on 01/26/21; Accepted on 04/27/21. | Evaluated by double blind review process.

DOI: https://doi.org/10.1590/1981-5271v45.3-20210023.ING

INTRODUCTION

Communication is an instrument of interaction between two or more individuals, a continuous, fluid process, in which the ideas of those involved in the interaction must be discovered and understood by both[1].

In health services, Clinical Communication is characterized as a very important process to ensure comprehensive care for the user. For it to be effective, the existence of the workers' willingness to actively participate in this movement is essential, aiming to improve the quality of interpersonal relationships through respect and empathy[2].

Health services are often permeated by technicism. This "strange environment" can cause different emotions in the user, such as fear of the unknown and anxiety due to their situation, which directly affects their autonomy. If the professional does not have an expanded view, communication will be fragile, as it will be directed at the pathology and not the individual, making care even more fragmented[3].

The complexity of the patients' biopsychosocial demands must be understood and worked through skills developed further than those fixed on technical and biomedical knowledge, with more extensive training in relation to the human being[4]. Therefore, humanization in health is seen as a growing demand[3].

Clinical Communication is the tool that can significantly influence those involved, bringing representations about their situation and impacting on the relationship between them and the professionals, with greater adherence to treatment and reduction of physical and emotional suffering[5].

However, in practice, there are several factors that prevent Clinical Communication from occurring as it should. Among them are: lack of information or predominance of technical information, resulting in cognitive distance between the parts; little investment of time[5]; difficulty for the health team to transform painful truths into clear and objective information; routine and overload of work activities and responsibilities, minimizing the consideration given to complaints from patients and their families and preventing qualified listening, which is essential for the individual's comprehensive care; the professionals' negative feelings in relation to the situation, such as anxiety and anguish[2]. One of the reasons for this is the lack of theoretical-practical training experiences, which warns of the need to work on this skill through training courses[2].

In the context of Medical Education, communication must be worked on throughout the entire student training. Therefore, it is important to emphasize that the National Curricular Guidelines (NCG) of the undergraduate medical course, established in 2001[6] and restructured in 2014[7], recommend in its article 4 the need for the development of knowledge, skills and attitudes of students regarding the clarity, empathy and confidentiality in verbal and nonverbal communication[7].

This pedagogical proposal is included in the integrated and competence-based curriculum of a higher education institution in the interior of the state of São Paulo, of which objective is a training process aimed at theoretical-practical articulation through constant reflection on the experienced reality and the gradual inclusion of the student in different scenarios, in order to develop autonomy and mastery of their performances during professional training[8]. In this curriculum, Clinical Communication is the student's expected competence in all undergraduate scenarios[9].

For the communication skill to be effectively exercised within the proposal of the integrated and competence-based curriculum, the teacher's role is essential in this process[2,10].

Considering the medical internship, it is important that the communication practice in this environment is worked out as proposed by the curriculum, in an integrated manner and observing the biopsychosocial aspects of the subject under care. However, a study with teachers and students involving this aspect of communication has shown that this skill has been studied superficially or implicitly, causing difficulty for its practice effectiveness[2,11].

In this sense, in addition to the academic approach, there are also challenges related to teacher training, as demonstrated by Ferreira et al.[12], which show the teacher's difficulty in dealing with this issue during the internship, raising questions about the operationalization of faculty and student training according to the National Curriculum Guidelines and the Course Pedagogical Project (CPP). Therefore, it is assumed that there are different understandings about the Clinical Communication concept and its theoretical-practical articulation.

Thinking of the health context, it is necessary to consider the actors' representation in this environment: how does the user request care? How does the professional see this individual and themselves in this scenario? What meaning is produced by both in this relationship[10]?

Therefore, it is necessary to analyze the training of internship students at a higher education institution in the interior of São Paulo regarding the Clinical Communication concept and skills.

This study aimed to question how teachers and students of a medical course internship understand the Clinical Communication teaching-learning process in an integrated and competence-based curriculum in the dialogical matrix, identifying the Clinical Communication meanings for the participants and which strategies are used in training to work with it.

METHOD

This is an excerpt from a professional Master's Degree thesis carried out at a public Higher Education Institution (HEI) in the Midwest region of the state of São Paulo, which has full-time Medical and Nursing courses, with an annual and serial structure and using active teaching-learning methods. It has a total of 480 medical students, 160 of which attend internship. Its curriculum is an integrated one, guided by the dialogical competence approach[13] and is divided into three main units: Systematized Educational Unit (SEU), containing the tutoring environment, of which learning is centered on Problem-Based Learning (PBL); Professional Practice Unit (PPU), which contains real and simulated practice scenarios (Professional Practice Laboratory - PPL); and Elective Unit[9].

The study was submitted to the institution's Research Ethics Committee (REC), under Certificate of Presentation for Ethical Consideration (CAAE) number 13307519.3.0000.5413, which was approved on June 3, 2019, under Opinion N. 3.364.859.

Due to the proximity to the end of the training and with the results of the study by Ferreira et al.[12], it was decided to investigate the perception of Clinical Communication in students attending the institution's medical internship, which was the inclusion criterion of the study. Regarding the teachers, all internship disciplines were considered. The actors were selected at random, only differing in the teaching-learning scenarios and the years they were attending in medical school for greater coverage.

The study sample was carried out by theoretical saturation, that is, when it is not possible to apprehend new data from new interviews[14].

The study started with two pilot studies with one student and one teacher to evaluate the interview instrument. After this moment, data were collected. The interviews were previously scheduled and carried out individually with the actors according to their availability, but they were transcribed and analyzed separately to achieve saturation for each group. The session started with the collection of identification data, followed by the interview using the trigger question "*What do you understand by Clinical Communication, based on the pedagogical proposal of the integrated and competence-based curriculum in the dialogic matrix?*". To guide possible interventions by the researcher, a previously established script was used, corresponding to the study objectives. The interviews were conducted from July 2019 to November 2019 and carried out exclusively by this researcher. All interviews were recorded, having an average duration of 15 minutes.

To preserve the participants' identity, the presentation of the results will follow the pattern: letter S for students or T for teachers, followed by the number of the organization of the interviews and year they are attending/teaching. For example: S5 - 5th year, S16 - 6th year, T8 - 6th year, T9 - 5th year.

The aim of this study was to comprehend the interviewees' understanding of the topic through previous knowledge, experiences and events, both personal and professional. For this purpose, the qualitative approach was chosen for this study.

The interviews were transcribed and submitted to content analysis, a method used by Bardin[15] and Minayo[16]. Content analysis provides the reader with information complementary to that text in order to attain better comprehension and evaluation of the content; it moves through the elements that comprise communication, which are the following: sender (or producer of the message) and receiver (individual or group that receives it[15]). Through this technique, it is possible to access the content of the expressed messages, with the construction and categorization of knowledge based on them.

The thematic content analysis is carried out in the following steps[16]:

- Pre-analysis: successive readings are carried out with different degrees of depth, seeking to obtain an overview of the setting, identify peculiarities, classify the data and outline guiding assumptions for further analysis;
- Exploration of the material: the sections are distributed according to the classification and a new reading of the material is carried out to establish a dialogue between the sections and the literature, with organized grouping of data and identification of the thematic categories
- Treatment of results, inference, and interpretation: the nuclei of meaning emerging from the excerpts that constitute the thematic categories, which must dialogue with the guiding assumptions, are identified. Moreover, the researcher must turn to the theoretical frameworks to support and interpret the findings.

RESULTS AND DISCUSSION

Out of the 17 students attending the 5th year of medical school, two refused to participate in the research due to lack of time and four did not return the contact. Regarding the 6th year students, 13 contacts were made, and one did not return the contact. Twenty-three randomly selected students participated, including 11 students attending the 5th year and 12 students from the 6th year. Of the total, 16 were female and seven male, with a mean age of 25 years.

Regarding the teachers, nine participated in the study, of which three taught the 5th year of the internship, two taught only

the 6th year and five taught both years. None of the contacted teachers refused to participate. Six teachers were male and three were female. The mean age was 50 years old, with years of education varying from 1979 to 2009. As for the academic degree, two had a doctoral degree, two had a master's degree and six were specialists, of which three were faculty teachers and six were teaching assistants.

In the data analysis, after identifying the nuclei of meaning, the thematic categories and subcategories emerged, as shown in Table 1.

Therefore, the set of concepts and characteristics will be presented through three thematic categories that will deal with the discussion of the Clinical Communication and curriculum topic, namely: 1) What involves Clinical Communication; 2) Development of Clinical Communication during the undergraduate course and 3) Proposals for the education of students and teachers at the internship.

What Clinical Communication Involves

For the participants, Clinical Communication is a dynamic process that broadly works to develop trust between users, professionals and family members. According to students and teachers, that occurs interpersonally between health professionals and patients, emphasizing the understanding of the development of relational attitudes with users, their own colleagues and the team.

> *"It is the ability to express to the patient and the family member about [...] the patient's clinical condition, as well as to communicate between professionals in the area who work together [...] "(T9 – 5th year)*

When talking about the development of communication, students refer to the ability of listening to and responding the patient's demands as facilitating elements in the therapeutic relationship; the teachers describe this process as that of explaining and guiding while using clear language and adapting it to the person's understanding, attaining greater possibilities of communication based on the understanding of what others comprehend.

> *"[...] I think that communication starts with listening [...], it is embracing and giving feedback, giving guidance, building a care plan together, building diagnostic hypotheses, have a clinical reasoning on what you received at the first listening". (T5 – 5th and 6th years)*

Studies show that Clinical Communication that cares about everyone involved becomes indispensable for the quality of health care, covering aspects of the creation and maintainance of therapeutic relationships with users and family members and making use of active listening to obtain information, work on communication skills and develop healthy and empathetic interpersonal relationships with other professionals[17,18].

To achieve comprehensive care, students and teachers reported the need to adapt the lanage used:

> *"[...] everything involves not only having theoretical knowledge, but also being able to translate it into a technical language when you are in a discussion with your team, as well as utilizing a simpler language to reach the patients' different socioeconomic and cultural levels [...] ". (S14 – 6th year)*

The concern with the language used can be observed among the professionals involved in the training, as, in practice, they observe a deficit in the behavioral repertoire regarding the development of communication when the use of "technical languages" with the patients predominates. Such behaviors are

Table 1. Thematic categories and subcategories of students and teachers on Clinical Communication in the curriculum.

GROUP	THEMATIC CATEGORIES	SUBCATEGORIES
STUDENTS	1. What Clinical Communication Involves: Participants and Skills	1a. Communication in interpersonal relationships 1b. Communication skills
	2. Development of Clinical Communication in undergraduate courses	2a. Strengthening communication over the years 2b. Communication fragility over the years
	3. Organization of the internship	3a. Weaknesses of the internship organization 3b. Proposals for teaching-learning process at internship
TEACHERS	1. What Clinical Communication involves: development and importance	1a. The development of Communication 1b. Importance of communication
	2. Development of clinical communication in undergraduate medical school	2a. Strengthening communication during the undergraduate course 2b. Fragility of communication at the undergraduate course 2c. Communication in pedagogical practice
	3. Proposals for the training of internship students and teachers	

shown as niches for great discussions about performance in this scenario[19].

Still regarding all care in communication as a tool for change, adherence and bonding, teachers mention concepts such as empathy in order to promote change in the patient's life.

> *"[...] Clinical Communication is also related to empathy [...]. When you understand the other as a human being identical to you, who will suffer with what they will hear, [...] you make better, more human communication". (T7 – 6th year)*

A positive effect is observed in users who are treated empathically, showing greater adherence to treatment, the development of feelings of trust and security with the professionals, greater satisfaction with the health service and with the care provided to them and/or their family, with an improvement in prognosis. As for the professionals, the gain by adopting an empathic posture in this environment is related to lower rates of depression, burnout (job stress) and greater job satisfaction[20].

Both students and teachers understand Clinical Communication as a dynamic movement that must be put into constant practice in the healthcare environment. It is observed that both are concerned with the language used in order to achieve the understanding and comprehension of all involved.

Development of Clinical Communication in undergraduate courses

Regarding this category, students highlight the biopsychosocial perspective and the encouragement of communication at the beginning of the undergraduate course. They report it is a well-studied concept in the first years of the course, especially in the setting of the Professional Practice Laboratory (PPL), which includes a psychologist, but also through tutorials, during the activities of the Professional Practice Unit (PPU) and between peers and with users, realizing how much its early inclusion into practice collaborates with communication development.

> *"[...] since the beginning, we can start establishing this communication in different areas, you know, either with the patient at the beginning of the first year [...], or with [...] the health unit team [...], with our colleagues". (S23 – 6th year)*

The students highlight the development of Clinical Communication during the undergraduate course as an evolution that occurs throughout the years through its inclusion into practice, using this learning at the internship.

> *"I think everything is part of the evolution." [...] in the first and second years, we also had a more prolonged contact with patients, but [...] There, we were thinking more about the issue of collective health, guidelines, prevention [...] . that we did from the first to the fourth year; it helps a lot now to establish bonds and [...] regarding the Clinical Communication skill itself [...]. " (S8 – 5th year)*

Teachers also report that communication development occurs gradually, as it is practiced in internships, because, according to them, the integrated curriculum favors the practice of communication right at the beginning of the course, allowing students to reach the internship with a more developed skill.

> *"Well, I understand that, as the curriculum has been integrated since the first year, and it works with [...] [the students'] entry into Primary Care, [...] I realize that communication skills are being built throughout the years and when we reach the internship, we perceive our students' differential skill in terms of having a more developed communication". (T5 – 5th and 6th years)*

As guided by the notebooks of the years[21,22], the students are gradually incorporated into the context of working to develop their performance in the presence of the presented needs. The literature points out that communication is an essential clinical competence for comprehensive care. According to the study, this educational process is gradual, starting from more basic contexts to more complex ones, aiming to have the student develop the knowledge, skills and attitudes as a basis for effective communication[23].

One weakness pointed out by students is that the development of communication is well developed at the beginning of the undergraduate course; however, after the third year, the predominance is of a more theoretical approach, without training or triggers.

> *"[...] later you start getting lost, in the third and fourth years we do not have an approach in that sense, so it is much more theoretical; sometimes there opens up something about communication, but it's very rare, [...], only afterwards you realize that it is something that was needed [...] ". (S12 – 6th year)*

For teachers, the lack of teacher training, with a predominance of biomedical training in some cases, is also a point of weakness that was pointed out.

> *"[...] the internship is a very difficult phase, [...] we have preceptors from [...] different specialties, in different scenarios, and many times what is built during the first years can be fragmented during the internship ". (T5 – 5th and 6th years)*

The teachers' training in the integrated and competence-based curriculum is very important for them to play the role of facilitator in learning. Development of the students' autonomy and encouragement towards the active learning process are

expected behaviors from this professional. Ferreira et al.[24] point out that, most of the time, the teacher is the professional who has an affinity for teaching and who starts to exercise their academic activities based on the assumptions of "learning to teach while teaching", being guided by the other teachers' models, who already work as teachers. The authors reflect that, in these cases, teaching is an activity that is secondary to the medical profession. This posture needs to be rethought, as it can damage the training of students and teachers.

Within the perspective of appreciation, teachers perceive some difficulty in putting communication into practice due to overwork, workload and undervaluation of the professional.

> *"[...] overwork, little time, undervaluation of professionals, it is very difficult to do it, really. It is beautiful [...] in theory, in practice, we have 3 hours to attend to dozens of patients with neoplasia, how are you going to pay attention to what the patient needs? It is impossible". (T3 – 5th year)*

Novaes et al.[25] evaluate that these teachers are usually physicians who work in assistance care, without having had pedagogical training in their curriculum, and reflect that in addition to working as a teacher, this professional also performs other activities in multiple scenarios, which can have a negative impact on their mental health. This is the concept of secondarization (from the Spanish term "*secundarización*") of the profession statute that occurs when the teacher is incorporated into the teaching environment, but without specific training and with difficulties in the didactic-pedagogical performance. The authors reflect on the importance of valuing the teacher in this context, investing in their training, discussing their understanding and the availability of the teacher to work with students and valuing their role in the training of students[26].

The interviewees also emphasize that the theoretical and practical disarticulation is observed after the third year onwards. The difficulty in the lack of standardization in each practice scenario and differences in the demand for care are also weaknesses pointed out by the teachers.

> *"So, up to the fourth year everything is OK, you see? [...] then, during the internship, they are monitored, they will have a preceptor wherever they are, [...] now imagine you, amidst the emergency room demand, do you understand? Where there are eighty people waiting in line, fifty on a stretcher, I do not know how many admitted to the hospital, and you have to handle it, then lose it[...] ". (T7 – 6th year)*

As reflections of the pedagogical practice, the teachers' speeches showed the importance of monitoring the student in the simulated scenario. The development of the skill to communicate with the teacher and the patient and encourage the capacity to communicate adequately and be a good professional is part of this practice in the undergraduate evolution.

> *"[...] developing greater communication skills, since they are carried out in small groups and everyone has to participate and speak. You encourage students to develop this communication skill [...] ". (T9 – 5th year)*

Another type of pedagogical practice highlighted here is to encourage seeking information about the patients so that the teacher knows the history and performs the monitoring. However, the student needs an example in the practice. For this purpose, going through the clinical rounds with students as a means of building communication skills and supporting them during the anamnesis synthesis at that moment are part of the teachers' pedagogical practice.

> *[...] they learn to perform an extremely complete anamnesis, and during the round it is not possible, they have to learn how to synthesize it, and I ask things on purpose, for them to realize that some things were missing". (T2 – 5th and 6th years)*

For the development of students' critical-reflexive thinking and the acquisition of theoretical-practical learning, the presence of the teacher as a mediator and facilitator of this process is essential. This relational and interaction movement provides the construction of knowledge[27].

It is perceived in this category that students and teachers understand the process of Clinical Communication, which must be increasingly developed during the undergraduate course; however, both perceive the fragmentation of this process at the internship, due to the organization of the scenarios, lack of teacher's training and the time required for such movements.

Proposals for training students and teachers

When reflecting on the internship organization weaknesses, students and teachers realize that the practice of communication at the internship is lacking, as there is little encouragement for this skill.

> *"In the beginning of medical school, in the first and second years, they demand that we see the patients as a whole [...] but [...] at the internship, they want you to be exactly the opposite of that, perhaps because internship physicians […] have a different idea than those who work with the first years". (S1 – 5th year)*

From the teachers' perspective, the curricular integration at the internship is not as well developed as in the first years of undergraduate school.

> *"When they reach the fourth to the fifth year, they are terrified when they arrive, [...] afterwards it improves, and I realize that up to the fourth year*

> *there is spirituality, there is demand, respectability, it is possible to demand, there is a work mechanism there, and after the fifth year it is completely different, there is no sequence which I think is a reasonable one. [...]. " (T8 – 5th year)*

Students emphasize the focus on aspects of the biological sphere. They report that communication skills are no longer addressed at the internship, with the absence of personalized assessment, feedback for student development, which increases the difficulty of communication in this environment. They report that the evaluation, when it occurs, depends on the teacher, without a systematized model, a view that the teachers share:

> *"[...] usually the students treat the case, [...] and only later I see it with them; many times, I do not follow exactly how the student treated the patient, I see that later and sometimes information is missing, data that were not asked, but interviews, conversations with patients and family members, they are their responsibility" (T9 – 5th year)*

Students report a lack of opportunity to be heard and embraced by conservatism and the difficulty some teachers have in providing space for this learning because, according to the students, they also have difficulties in dealing with the patients' subjective issues.

> *"[...] they are not very willing to listen. The [institution] in a way even opens up more space for us to talk, [...] so we have an openness with them, but the physician [...] is a professional who is used to not taking orders, they give orders, they are more conservative and more closed-minded, they are less open to change". (S1 - 5th year)*

According to the students' experience at the internship, many teachers end up turning more to providing care than teaching, so that there is no orientation on how to proceed in the hospital environment, including lack of communication with other care professions.

> *"[...] we are very concentrated on the medical team at the internship, so, we have little contact, [...] for instance, today we see through the [anamnesis of] interconsultations, we do not see conversations, we only see whatever was written in the system". (S3 – 5th year)*

Students also feel insecure in relation to the handling of cases due to the lack of homogeneity in the teacher's or on-duty physician's attitude regarding learning.

> *"[...] there are some who go and see the patient, there are others who do not do it, there are some who do not get up from the chair, you know, they only tell you to do things. Then, there are others who come and see your history, correct it, go with you, examine the patient, guide you, then you have two profiles". (S17– 6th year)*

Another important weakness reported by them is the small number of teachers to head the internship, a difficulty that makes the students "do the job", harming the learning process, with a very extensive workload.

> *"Our problem at the internship are trainings that are very uneven, so in some internships they really want us to work, so this issue of learning, of developing new techniques, it does not really exist". (S7 – 5th year)*

A study on medical students' perception regarding the learning assessment at the medical internship shows weaknesses in the internship organization, such as assessments based on personal characteristics and not on performance; lack of empathy and closeness to the student; teacher's judgment based on the time spent in care and not on quality of care; and lack of clearly defined objectives for this scenario. On the other hand, as potentials, students were very emphatic in the feedback that teachers occasionally provided to them, in addition to the daily assessment of the practice in the scenario. These two points, according to a study, were predominant factors in training[28].

Lima et al.[29], in a study carried out at a public university in Fortaleza, demonstrate as a potential the importance of the teacher's role as a mediator and facilitator in the internship scenario. As weaknesses, they point to the lack of the teachers' experience with active methodologies, distancing from the students, lack of case discussion, high user demand and the fact that the scenarios are not prepared for receiving the students.

One possibility for improvement explored by students is to be able to better integrate other professional areas related to user assistance to better develop a systematized communication throughout the undergraduate course, a view that is shared by teachers:

> *"Not only improving communication, but perhaps developing a dialogue with the students over the four years or even having a little more contact with the professional who performs the assistance or having the assistance, I think it would be a good way to improve this communication [...] sometimes if you had developed it before, if you already had a certain capacity to reach the fifth year with good communication skills, perhaps the gain would be greater during the internship". (S5 – 5th year)*

> *"[...] we had a team, several professionals came to the ward during the week and I always worked with them with a discharge plan on the first day of hospitalization. I see that this has to be worked with the teachers, assistants frequently do not have this perception, [...] it is a matter of training [...], and our training was a biomedical one". (T1 – 6th year)*

Thinking about the quality of the students' life at the internship, Meyer et al.[30] discussed these aspects and identified

DOI: https://doi.org/10.1590/1981-5271v45.3-20210023.ING

issues such as fatigue, problems in adapting sleep and depressed mood due to the difficulty in reconciling practical internship hours with the studies. They also report the large demand for care at the internship as a source of suffering due to lack of time in the discussion of these cases, making it impossible for the studies to be carried out simultaneously with practical work.

Still as proposals for organizing the internship, students and teachers suggest investment in remuneration, professional appreciation and the hiring of teachers.

> *"The first thing is the appreciation [...] it is a much broader thing, but in a simpler way I think it would be to appreciate more the professional who is here with the salary, [...] when the professional is underpaid, they have no incentive to continue encouraging this complete training". (S4 - 5th year)*

Teachers reflect on the importance of having time to discuss cases with students and being closer to the student when handling cases.

> *"[...] the clinical round, when you have 30 patients, has to last the entire morning and afternoon, but in practice it does not work like that, many times you cannot sit with a student; very often we take two or three cases and talk a little more, if the cases are more interesting, but you cannot do that with everyone because it is impossible [...] ". (T3 - 5th year)*

Barreto et al.[31] also demonstrate these weaknesses in the contact with students due to the training of teachers using a different methodology, justifying the need for the training to be able to act as a mediator of the students' learning.

Considering the abovementioned facts, a proposal for curricular management, CCP and people management is necessary, so that changes about the preceptorship process can be implemented at the internship with regard to Clinical Communication.

CONCLUSIONS

The results show the perception of students and teachers about Clinical Communication and the institution's curricular proposal, showing they understand the concept and the importance of Clinical Communication for the training and professional practice. On the other hand, both teachers and students report gaps in the development of this skill during the undergraduate course, showing difficulties in the operationalization of the curriculum used by the institution.

They also disclose the importance of understanding concepts about the students' training and professional practice; however, they also demonstrate difficulties regarding the teacher's role as mediator and facilitator that they perform within this curricular proposal.

When evaluating the students' proposals, demands were raised about the structuring of the curriculum regarding the presence and development of the teacher's role as a mediator in the training process, as well as the need for continuous feedback and the possibility of having some space for them to reflect on their practice with the support of teachers working in communication, as it occurs during the first years. One can think about the construction of guidelines for intervention and formalization in the pedagogical project and the curricular axis of the course years, seeking to strengthen the listening space for internship students to reflect on their practice and to be able, through this movement and strategy, to further signify their learning.

In relation to the teachers' statements, demands were raised in relation to professional appreciation and workload they dedicate to the training of students within the curriculum proposal. One can think of interventions in the sense of appreciation for all the teacher's efforts in this process.

The study gave rise to two intervention projects: a reflection workshop for teachers that teach students from all years of the institution and a construction workshop with students for curricular proposals.

The exploration of the topic in an integrated curriculum and in the dialogical approach of competence may contribute to future local strategies and other experiences, since the topic is addressed in the NCGs of the medical course, but it may also bring contributions to other professionals in the health area.

AUTHORS' CONTRIBUTION

Ana Glaucia Paulino Lima: study concept, data organization, formal analysis, research, methodology, project management, resources, validation, visualization. Danielle Abdel Massih Pio: study concept, data organization, formal analysis, research, methodology, project management, resources, supervision, validation, visualization, writing – review and editing. Ana Carolina Nonato: data organization, visualization, writing – original manuscript, writing – review and editing. Mara Quaglio Chirelli and Roseli Vernasque Bettini: supervision, validation, visualization.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

SOURCES OF FUNDING

The authors declare no sources of funding.

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