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Short communication

# Communication skills teaching in Brazilian medical schools: What lessons can be learned?

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### ABSTRACT

**Objective:** To assess current practices in communication skills (CS) teaching in Brazilian medical schools (MS), looking for similarities and differences with other countries.

**Methods:** This study was performed with 162 out of the 237 accredited Brazilian MS (68.35%). The quantitative data were analyzed using descriptive statistics and qualitative data using content analysis. **Results:** 104 MS (64.2%) reported formal CS training. CS were more commonly taught in the pre-clinical years, by physicians and psychologists. Compared to other countries, Brazil was unique in offering training for “acolhimento” (“embracement”), which is a Brazilian Government strategy that requires that all those connected with healthcare delivery, from administrators to practitioners, and all allied health personnel “embrace” a dedication to caring for patients and the communities in which they live.

**Conclusions:** Formal CS teaching in Brazilian MS is less frequently seen in MS curriculum compared to reported data from other countries. The CS teaching of “embracement” is unique to Brazil.

**Practice implications:** This study adds to the literature by identifying the CS teaching of “embracement” in Brazilian MS, which could be considered outside Brazil.

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## 1. Introduction

Physician–patient communication is at the core of medical practice with evidence-based studies demonstrating that effective communication skills (CS) improve patients’ medical and psychological outcomes, as well as patient and physician satisfaction [1–4].

Guidelines and consensus papers support systematic communication training of medical and allied health professionals [5–11]. Since the 1990’s, many medical schools (MS) worldwide have adopted formal CS curricula. Systematic reviews describe effective interventions for teaching and learning CS [12,13].

The world has become increasingly interconnected and interdependent, and educational systems can improve by sharing their teaching programs with each other [14].

After a literature review of comprehensive national surveys of the CS teaching curricula, published surveys from only three countries were found: US [15], UK [16–18] and Spain [19]. In the US, by 1999, 95.6% of the MS reported teaching CS [15]. In the UK, by

1998, almost all MS reported teaching CS [18]. In Spain, by 2005, 71.4% MS reported teaching CS [19]. We found no comprehensive Brazilian survey of CS curricula.

Since 2001, the Brazilian guidelines for undergraduate medical education (BGUME) have required that CS be taught in Brazilian MS [20,21]. Brazil is a vast country, highly diverse in terms of geography, demographics, culture, as well as socioeconomic and health conditions [22,23]. The Brazilian National Health System, the Unified Health System (SUS, as per the Portuguese acronym for *Sistema Único de Saúde*) provides free access to equal, humanistic and comprehensive healthcare to the entire Brazilian population [23,24]. One strategy to implement SUS principles is the “acolhimento” (translated into English as “embracement”). It requires that all those connected with healthcare delivery “embrace” a dedication to caring for patients and the communities in which they live [25–27]. Brazilian physicians are expected to communicate effectively with the multiprofessional teams, patients, families, and community members.

We wondered, given the imperative to teach CS in Brazilian MS, about the current status of CS teaching in Brazil. In what ways are the curricula responsive to the healthcare system demands? What specific skills and topics are being taught that might be unique to Brazil, but might be of interest to educators in other countries?

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In order to answer these questions, we conducted a national survey to assess current practices in CS teaching in Brazilian MS, looking for similarities and differences with other countries.

## 2. Methods

### 2.1. Study design and participants

This survey was conducted after approval of the research project by the Federal University of Santa Catarina Research Ethics Committee (protocol No. 551.143//2014, CAEE: 25541213.7.0000.0121), from January 2015 to June 2016. The participants were representatives of all 237 Brazilian MS registered in the national information database on Higher Education Institutions' electronic system, available at <http://emec.mec.gov.br>. The deans of the medical courses on the institution's website were contacted by telephone or email. If they agreed to participate in the study, a consent form was emailed to them with detailed explanation about the study. When there was no response from the course dean, a faculty member from the same institution was contacted. The final phase of recruitment was performed at the 53rd Brazilian Medical Education (ME) Conference, held in 2015, where faculty members of institutions who did not respond were approached and invited to participate.

### 2.2. Data collection

Data was collected using a self-administered questionnaire with closed and open-ended questions, including the following variables: whether CS was offered by the MS; stage of the course that taught CS; medical specialties and areas of knowledge involved in CS teaching; and CS content and teaching methods. This questionnaire is available on request.

In order to analyze the content validity of the questionnaire, we pilot-tested it with a representative sample of 10 university CS faculty who attended the 52nd Brazilian ME Conference. The final version had a Content Validity Index of  $0.92 \pm 0.02$ .

### 2.3. Data analysis

The quantitative data were analyzed using descriptive statistics and the qualitative data using content analysis.

## 3. Results

### 3.1. Communication skills programs

The response rate for the survey was 68.3% (162 schools); 104 among them (64.2%) offered formal CS training. The distribution of 413 CS programs offered by these MS, by curriculum design and stage of the course is presented in Table 1. The programs were generally offered in the pre-clinical years. Only 7 MS had CS as a

longitudinal course over the pre-clinical and clinical years of training.

### 3.2. Teachers involved in CS training and CS content and their teaching methods

The CS programs were frequently taught by physicians, mostly those in internal medicine ( $n = 83$ , 79.8%), psychiatry ( $n = 15$ , 14.4%) and family medicine ( $n = 14$ , 13.5%). However, interprofessional instruction was also given by professionals from many other areas, psychologists being the most frequent ( $n = 41$ , 39.4%) followed by nursing and sociology ( $n = 11$ , 10.6% each). Among the diverse methods used to teach CS, the most frequent were lectures ( $n = 104$ , 100%), case discussions ( $n = 79$ , 76%), followed by video triggers for discussion ( $n = 74$ , 71.1%), roleplays ( $n = 72$ , 69.2%), narrative ( $n = 47$ , 45.2%) and use of standardized patients ( $n = 44$ , 42.3%).

### 3.3. Communication skills content

The most frequently mentioned contents were both general non-verbal and verbal CS. The only content not present in other countries was CS for "embracement" (Table 2).

## 4. Discussion and conclusion

### 4.1. Discussion

When compared to the US and UK MS, it is evident that Brazil has less adherence to the BGUME. In the US, an important driver for the incorporation of CS into MS core curricula was the Liaison Committee on Medical Education requirement of CS for school accreditation [28], and the requirement of the National Board of Medical Examiners, as a condition of licensure that all graduating medical students pass a standardized patient Objective Structured Clinical Examination evaluating CS [29]. In the UK, an important motivation for the incorporation of CS into MS core curricula was *Tomorrow's Doctor* program, launched by the General Medical Council, which regulates ME standards and evaluation [30]. Clearly, if Brazilian educational leaders want to enforce adherence to CS teaching guidelines, oversight related to accreditation would be necessary.

The present survey showed that CS programs in Brazil are more often provided in the pre-clinical years of MS. This pattern is similar to that seen in the US [15] and Spain [19]. In the future Brazil should consider, as is being done by many American MS, the incorporation of CS programs in the clinical years of medical training [31].

The predominant CS instructors were physicians and psychologists, similar to what was found in the UK in 1998 [18]. However, more recently, a range of teachers with diverse backgrounds have been involved in this teaching in the UK [30]. This may support a

**Table 1**

Distribution of 413 communication skills programs offered by 104 Brazilian MS, by curriculum design and year of training (June 2016).

Programs by year of medical course						
Schools	1st	2nd	3rd	4th	>4th	Total
Curriculum Design	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Traditional (n = 42)	27 (28.7)	37 (39.4)	10 (10.6)	6 (6.4)	14 (14.9)	94 (100)
PBL (n = 38)	68 (30.8)	56 (25.3)	42 (19.0)	35 (15.9)	20 (9.0)	221 (100)
IM (n = 13)	23 (37.1)	11 (17.8)	10 (16.1)	9 (14.5)	9 (14.5)	62 (100)
Other (n = 11)	15 (41.7)	12 (33.3)	6 (16.7)	2 (5.5)	1 (2.8)	36 (100)
Total (n = 104)	133 (32.2)	116 (28.1)	68 (16.5)	52 (12.6)	44 (10.6)	413 (100)

IM – Integrated and Modular; PBL = Problem-Based Learning.

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