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ABEM consensus for the brazilian medical schools' communication curriculum

Consenso ABEM para o ensino de comunicação nas escolas médicas brasileiras

Suely Grosseman[1] sgrosseman@gmail.com
Newton Key Hokama[2] newton.hokama@unesp.br
Agnes de Fátima Pereira Cruvinel[3] agnes.cruvinel@uffs.edu.br
Ana Cristina Franzoi[4] anacristinafranzoi@gmail.com
Eliane Perlatto Moura[5] elianeperlatto@gmail.com
Evelin Massae Ogatta Muraguchi[6] evelinmuraguchi@hotmail.com
Fernanda Patrícia Soares Souto Novaes[7] fernanda.patricia@univasf.edu.br
Gustavo Antonio Raimondi[8] gustavo.raimondi@gmail.com
Josemar de Almeida Moura[9] josemar.a.moura@gmail.com
Lara de Araújo Torreão[10] lara.torreao@gmail.com
Maria Amélia Dias Pereira[11] pereiramamelia@gmail.com
Miriam May Philippi[12] miriamphilippi2@gmail.com
Mônica da Cunha Oliveira[13] monicaoliveira@bahiana.edu.br
Rosana Alves[14] rosana.alves@professor.fpp.edu.br

ABSTRACT

Introduction: Communication is an essential competence for the physician and other professional categories, and must be developed their professional training. The creation of a communication project including a Brazilian consensus aimed to subsidize medical schools in preparing medical students to communicate effectively with Brazilian citizens, with plural intra and inter-regional characteristics, based on the professionalism and the Brazilian Unified System (SUS) principles.

Objective: The objective of this manuscript is to present the consensus for the teaching of communication in Brazilian medical schools.

Method: The consensus was built collaboratively with 276 participants, experts in communication, faculty, health professionals and students from 126 medical schools and five health institutions in face-to-face conference meetings and biweekly or monthly virtual meetings. In the meetings, the participants' experiences and bibliographic material were shared, including international consensuses, and the consensus under construction was presented, with group discussion to list new components for the Brazilian consensus, followed by debate with everyone, to agree on them. The final version was approved in a virtual meeting with invitation to all participants in July 2021. After the submission, several changes were required, which demanded new meetings to review the consensus final version.

Result: The consensus is based on assumptions that communication should be relationship-centered, embedded on professionalism, grounded on the SUS principles and social participation, and based on the National Guidelines for the undergraduate medical course, theoretical references and scientific evidence. Specific objectives to develop communication competence in the students are described, covering: theoretical foundations; literature search and its critical evaluation; documents drafting and editing; intrapersonal and interpersonal communication in the academic-scientific environment, in health care and in health management; and, communication in diverse clinical contexts. The inclusion of communication in the curriculum is recommended from the beginning to the end of the course, integrated with other contents and areas of knowledge.

Conclusion: It is expected that this consensus contributes the review or implementation of communication in Brazilian medical schools' curricula.

Keywords: Communication; Medical Schools; Curriculum; Undergraduate Medical Education; Consensus.

[1]Universidade Federal de Santa Catarina, Florianópolis, Santa Catarina, Brazil.
[2]Faculdade de Medicina de Botucatu, Botucatu, São Paulo, Brazil.
[3]Universidade Federal da Fronteira Sul, Chapecó, Santa Catarina, Brazil.
[4]Universidade Federal do Rio de Janeiro, Rio de Janeiro, Rio de Janeiro, Brazil.
[5]Universidade João do Rosário Vellano, Belo Horizonte, Minas Gerais, Brazil.
[6]Pontifícia Universidade Católica do Paraná, Curitiba, Paraná, Brazil.
[7]Universidade Federal Do Vale Do São Francisco, Petrolina, Pernambuco, Brazil.
[8]Universidade Federal de Uberlândia, Uberlândia, Minas Gerais, Brazil.
[9]Universidade Federal de Minas Gerais, Belo Horizonte, Minas Gerais, Brazil.
[10]Universidade Federal da Bahia, Salvador, Bahia, Brazil.
[11]Universidade Federal de Goiás, Goiânia, Goiás, Brazil.
[12]Centro Universitário de Brasília, Brasília, Distrito Federal, Brazil.
[13]Escola Bahiana de Medicina e Saúde Pública, Salvador, Bahia, Brazil.
[14]Faculdades Pequeno Príncipe, Curitiba, Paraná, Brazil.

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RESUMO

Introdução: *A comunicação é uma competência essencial para o(a) médico(a) e outras categorias profissionais, e deve ser desenvolvida durante sua formação profissional. A elaboração de um projeto de comunicação, incluindo um consenso brasileiro, visou subsidiar as escolas médicas a preparar os estudantes de Medicina para se comunicarem efetivamente com os(as) cidadãos/cidadãs brasileiros(as), de características plurais intra e inter-regionais, pautando-se no profissionalismo e nos princípios do Sistema Único de Saúde (SUS).*

Objetivo: *Este manuscrito apresenta o consenso para o ensino de comunicação nas escolas médicas brasileiras.*

Método: *O consenso foi construído colaborativamente com 276 participantes, experts em comunicação, docentes, profissionais de saúde e discentes, de 126 escolas médicas e cinco instituições de saúde, ao longo de nove encontros presenciais em congressos e de encontros virtuais quinzenais ou mensais. Nos encontros, compartilharam-se as experiências dos participantes e o material bibliográfico, incluindo os consensos internacionais, e apresentou-se o consenso em construção, com discussão em grupos para elencar novos componentes para o consenso brasileiro, seguida por debate com todos para pactuá-los. A versão final foi aprovada em reunião virtual, com convite a todos(as) os(as) participantes em julho de 2021. Após submissão, diversas alterações foram requeridas, o que demandou novos encontros para revisão da versão final do consenso.*

Resultado: *O consenso tem como pressupostos que a comunicação deve ser centrada nas relações, pautada nos princípios do SUS, na participação social e no profissionalismo, e embasada nas Diretrizes Curriculares Nacionais do curso de graduação em Medicina, em referenciais teóricos e nas evidências científicas. São descritos objetivos específicos para desenvolver a competência em comunicação nos estudantes, abrangendo: fundamentos teóricos; busca e avaliação crítica da literatura; elaboração e redação de documentos; comunicação intrapessoal e interpessoal no ambiente acadêmico-científico, na atenção à saúde em diversos contextos clínicos e na gestão em saúde. Recomenda-se a inserção curricular da comunicação do início ao final do curso, integrada a outros conteúdos e áreas de saber.*

Conclusão: *Espera-se que esse consenso contribua para a revisão ou implementação da comunicação nos currículos das escolas médicas brasileiras.*

Palavras-chave: *Comunicação; Escolas Médicas; Currículo; Educação de Graduação em Medicina; Consenso.*

INTRODUCTION

The word "communicate" derives from the Latin word *communicare* and means to share, to make public, to relate to, from which the word "commune" also originated, which means to share with everyone, to participate, to do something in common, to tune into feelings, thoughts and actions[1]. Thus, communication is relational and, as Araújo and Cardoso state, it is a "social practice"[2]. For Paulo Freire, communication is an essential condition of human beings, and without it, human knowledge would be impossible, as the cultural and historical construction of human reality requires "intercommunication" and "intersubjectivity" based on dialogicity[3]. Therefore, the educator, who aims to expand the perspectives and possibilities for the student's assertion as a person in the society, through reflection and action on reality, must problematize the world, in a dialogic and solidary way[3,4].

Therefore, the importance of dialogue should always be taken into account by educators/teachers of the medical course and physicians. In the past, however, teaching was teacher-centered and the clinical encounter was physician-centered and based on the biomedical model, focused on the disease, limiting the active participation of the students and those under medical care. In the teaching process, in clinical reasoning and in decision making, their knowledge, experiences, perspectives and practices, as well as their values, were not taken into account[5,6].

In health care, this reality started to change in the 1970s, when studies demonstrated that the biopsychosocial model[7], encouraging the active participation of the person under care and attentive listening and empathy[8] generated better health outcomes. Some proven outcomes were: decrease of uncertainties in people under care and increase in their trust, security, adherence to the therapeutic plan, autonomy and responsibility for self-care, as well as better control of chronic diseases, including hypertension and diabetes and less stress, anxiety and depression. Family members also felt less anxious and stressed, and physicians achieved greater diagnostic accuracy and effectiveness in their care. As a result, everyone was more satisfied[9-17].

The importance of communication in interdisciplinary and interprofessional teamwork was also verified – considering the person under care and their family members / caregivers as part of the team – for the prevention of avoidable harm in health care and, therefore, to ensure the safety of the person under care[18-25]. It was demonstrated that the greater effectiveness of collaborative work required a shared leadership, respect for all involved, with their listening, recognition and appreciation of their contribution to the team's mission, and through frequent, assertive and conciliatory dialogue, would provide the fast and effective flow of information, the construction and maintenance of relations, clarity of roles and functions of each participant and the management of uncertainties, conflicts, adverse events and errors[18-27]. As a result, the person under care accepts the treatment better, has better health outcomes, takes less risks and feels more satisfied; team members work more effectively and feel greater well-being; and, there is greater efficiency in the services provided by the team and access to care, and the hospital length of stay, unplanned hospitalizations and institutional costs are reduced[18-27].

On the other hand, it was found that when communication in teamwork was ineffective, there were more errors in health care, including delays in diagnosis and treatment and an increase in medication and procedural errors[19-22]. Their most frequent causes were the omission of important clinical information, verbal prescription, illegible writing in medical records and files and/or the absence of the name, signature and stamp/digital certification of the professional responsible for the care. These problems occurred more frequently during the transition of care between shifts, in transfers between sectors and between health institutions, and in emergency situations. Proven barriers to communication in teamwork include hierarchy, little regard for the opinion of its members, failure to include the person under care and their family members/caregivers as part of the team, and little clarity about the role and functions of the team member, which are corroborated by the instability of the teams and/or transitoriness of its members and the assignment of tasks to new members, without support and prior qualification, among others[18-25].

As for the qualification for teamwork, a recent systematic review of the resources in the literature on communication for health professionals during the Covid-19 pandemic concluded that most articles and documents were directed at the physicians, and there was a gap related to the resources for non-medical professionals. Topics that required greater consideration, indicated by the authors, included: communication strategies in telehealth, cultural sensitivity, empathy, compassion, loss, grief and moral distress[28] caused by the witnessing of inappropriate attitudes and actions or the need to make decisions that go against one's own moral values, often due to the scarcity of resources[29].

The importance of training health professionals for the 21st century, so they can effectively communicate in collaborative interdisciplinary/interprofessional, intersectoral and transnational teamwork, in health leadership and in local, regional, national and global politics has been highlighted. This competence is necessary so that teams can act in a responsive way to the constant changes in local, national and global health needs, favoring the transformation of reality (transformational

education), and to improve "health systems in an interdependent world", promoting the health of populations, universal equity in health, social justice, global socioeconomic development and human security[30]. In this context, human health must be understood as part of a web of interdependent relationships with life in a broader sense, dependent on the consolidation of relationships of solidarity and individual, collective and environmental care[31], without territorial boundaries. As stated in the National Curriculum Guidelines (DCN, Diretrizes Curriculares Nacionais) for the undergraduate medical course, health care must preserve "biodiversity with sustainability", respecting the relationships between "human beings, the environment, society and technologies"[32].

Since the 1990s, the model of care centered on relationships has emerged[33], recognizing that, in addition to the relationship with the person under care, all the relationships created at each moment and in each space of health care influence each other and that care is interdependent on these relationships. This means that each person involved in this care influences its results, bringing to this encounter their subjectivity, with a personality and life story and their relationships with themselves, their emotions, interpretations, perspectives, needs, expectations and choices, and their own knowledge and values. Thus, the physician must be aware of how they, their emotions and all of their subjectivity, as well as those of other people involved in care, contribute to the care outcomes[33-36].

The knowledge built on effective communication processes and components and on the effectiveness of their teaching[37] contributed to the development of models to construct the clinical encounter and, among them, the method centered on the person under care[38], the SEGUE (Set the stage, Elicit information, Give information, Understand the patient's perspective, and End the encounter) method[39], the Calgary-Cambridge guide[40,41] and the Four Habits Model[42]. Moreover, consensuses were created for the teaching of communication in undergraduate medical courses[43-52]. As professionalism is a construct, whose components are essential to medical practice[52-56] (as well as to the practice of other professional categories), it is one of the bases of communication in some consensuses, such as in the ones from the United Kingdom[46,51]. The security of the person under care, while part of professionalism, is another basis of communication in the most recent UK consensus[51].

Several books have also been published to support the teaching of medical communication in general and in the clinical encounter. Some of them are mentioned here to provide greater familiarity to those interested in the topic[2,38,57-62], but they are just the "tip of the iceberg" amidst the existing vastness.

The international consensuses for the teaching of communication partially meet the needs of medical training in Brazil, considering that its population exceeds 200 million inhabitants, which has different intra and inter-regional characteristics and needs[63], and that its public health system - the Brazilian Unified Health System (SUS, Sistema Único de Saúde) – has as principles the universality (egalitarian access to health services for all individuals[64,65]), integrality (integral vision of the human being, with comprehensive and effective actions in health[64,65]) and equity (respect for the uniqueness and subjectivity of each person, considering their individual and collective characteristics and needs, without any kind of prejudice or privilege, prioritizing vulnerable and at-risk groups or categories, to defend dignified treatment and guarantee social justice[64,65]). The SUS also includes the social control guideline, which presupposes the active and daily participation of the population in discussions to direct health services and actions in all of their instances, so that the system meets their needs and interests [64]. Embracement, which includes listening to the users of the Unified Health System (SUS) and other Brazilian citizens, is part of the national humanization policy to increase social participation and meet the health needs of the population[64,66].

The DCNs, introduced in 2001, aimed to align medical education with the learning needs of the students and with the health needs of the population according to the SUS. In the DCNs, communication was one of the six skills to be achieved by medical school graduates[67]. After the "More Doctors Program" (PMM, *Programa Mais Médicos*) in 2013[68], the guidelines were revised, resulting in the 2014 version of the DCNs[32]. The previous focus on six competencies to be achieved changed to competencies in relation to the areas of health care, health management and health education. Communication permeates most processes in these three areas of competence.

Being aware of the importance of training Brazilian physicians to effectively communicate when attending to the Brazilian population, while following the principles of the SUS, ABEM developed a communication project, containing among its objectives the construction of a consensus for its teaching in Brazilian medical courses[69,70]. The aim of this manuscript is to present the consensus for the teaching of communication in Brazilian medical schools.

METHOD

The creation of the consensus started in 2014[69]. Its construction was carried out in a collective and collaborative manner. According to Innes and Booher[71] and Innes[72], a collaboratively constructed consensus constitutes "a set of practices" in which people representing different interests

meet for a long-term dialogue, mediated by a facilitator, to address an issue or concern and arrive at a joint proposal. Its construction process must contain the following criteria: include representatives with different levels of interest; be guided by goals, tasks and practices shared by the group; allow participants to actively interact throughout the process, encouraging creative thinking; incorporate high quality information and evidence; reach an agreement on their meanings; and seek consensus by agreement, after broadly exploring the answers to the differences, through discussions[65-66].

To ensure the participation of as many representatives as possible and their diversity, the discussions took place in person between 2014 and 2018 in six workshops held at the Brazilian Congresses of Medical Education promoted by ABEM, and three specific events on communication. The total number of participants was 276, including communication experts and teachers, students and other professionals interested in the area, from 126 higher education institutions in the medical and health area, four Health Secretariats and one Health foundation. One group met virtually, every two weeks or monthly, after the first in-person workshop.

Each in-person meeting lasted from four to eight hours and its dynamic consisted of sharing experiences in the teaching of communication and bibliographic material brought by experts, in addition to international consensuses, as they were being published[40-50] and the presentation of the version under construction of the Brazilian consensus offered by the organizers. New knowledge, skills and attitudes that should be part of the consensus were then discussed in small groups, which were subsequently presented to all the participants, with debates and agreement on the content to remain, confirmed by voting. As several components of professionalism were listed in the construction process, one of the workshops was aimed to discuss which components should be included in the consensus. The decision was unanimous to keep all of them and to consider professionalism as one of the bases of communication. The virtual meetings followed the same dynamics as the in-person meetings but lasted from one and a half to two hours.

The consensus was finalized in 2020 by the virtual group. However, the new communication challenges highlighted throughout the Covid-19[73] pandemic required its review.

The semifinal version of the consensus was presented in July 2021 at a meeting held on ABEM's virtual platform, with an invitation being sent to its directors and all those who had participated at some point in its construction process, when changes were suggested to be included in its final version, which was unanimously approved. After being submitted to the present journal, one of the opinions demanded new virtual meetings to consider the listed recommendations. The new final version was approved in a virtual meeting with an invitation being sent to all the participants of the consensus at the end of February 2022.

Considering the importance of the material shared by the participants throughout the consensus construction process and also the lack of familiarity that some readers might have in relation to some of the mentioned aspects, unlike other consensuses, this one contains bibliographic references in some of its specific objectives. We would like to clarify that articles and books cited as references were selected according to their relevance, aiming to support educators in the teaching of communication; however, without the intention of exhausting the literature. The explanation of some concepts and terms are also provided in a separate table, to facilitate their understanding by readers who may not know them.

RESULTS AND DISCUSSION: THE CONSENSUS

The teaching of communication in medical schools should have the *overall objective* of developing knowledge, skills and attitudes in the medical student, so that, when they graduate from the course, they can demonstrate competence when communicating with the people involved in the academic-scientific environment, in health care and health management.

The people involved include students, faculty, physicians, professionals in the healthcare area and other areas of knowledge, members of the interdisciplinary and interprofessional team, employees, researchers, managers, people under care, their family members, caregivers, guardians, loved ones, interpreters, people who respond for them, families, social groups, the community and its representatives and other people with whom the physician has a relationship in their professional performance.

Communication must be *based on* relationships, being grounded on professionalism, on the principles of the SUS and on social participation. Medical training must be guided by the DCNs and be based on theoretical references and scientific evidence. The DCNs establish that the medical course must provide a "humanistic, critical, reflective and ethical" training, and that it should develop in the student the

> *Capacity to act at the different levels of health care, with actions to promote, prevent, recover and rehabilitate health at the individual and collective levels, with social responsibility and commitment to the defense of citizenship, human dignity, the integral health of the human being and having as transversality in its practice, always, the social determination of the health and disease process*[32].

The DCNs also establish that, in health care, the student must be trained to act, considering "always the biological, subjective, ethnic-racial, gender, sexual orientation, socioeconomic, political, environmental, cultural, and ethical dimensions, and other aspects that comprise the spectrum of human diversity that make each person or each social group unique"[32], which is in line with the principles and guidelines of SUS[64] and constitutes one of the components of professionalism[52-56], which includes:

1. Bioethics and Ethics, which involve
   1.1. Respect for
      1.1.1. human dignity and freedom of individual and social choice, considering the uniqueness of each person or social group, in the cultural, ethnic-racial, spiritual, socioeconomic and environmental plurality, as well as of gender and sexual orientation and choices, values, beliefs, perspectives and preferences;
      1.1.2. the privacy and modesty of the person under care;
      1.1.3. the autonomy of the person under care and responsibility for its promotion;
   1.2. Subordination of self-interest in favor of the interests of people under one's care and of their family members / caregivers;
   1.3. Recognition of professional limitations,
   1.4. Secrecy and confidentiality;
   1.5. Responsibility for the safety and comfort of the person under care.
2. Honesty, probity and integrity;
3. Demonstration of humanistic values, such as altruism, empathy, compassion, solidarity, sensitivity, understanding, interest and affection;
4. Accountability in fulfilling the professional contract, with responsibility, responsiveness, reliability in actions and legal subordination to obligations;
5. Social responsibility, being committed to the defense of citizenship, human dignity, and the integral health of the human being;
6. Commitment to excellence, academic and professional merit, as well as lifelong learning;
7. Effective communication:
   7.1. *intrapersonal:* self-awareness (presence, recognition and management of one's own emotions and self-care), reflective practice, critical thinking and adaptability (acknowledgement of limitations and seeking help, acceptance and provision of constructive feedback, resilience, flexibility to transform knowledge and one's own practice and dealing with high levels of complexity and uncertainty);
   7.2. *interpersonal* (detailed in the consensus).

In the medical course *curriculum*, communication must be included from the beginning of the course and continue until its end. The contents must have increasing complexity and be appropriately integrated with other contents, having the "Human and Social Sciences as a transversal axis" and the inclusion of "transversal topics [...] that involve [...] "human rights" and [...] public policies, programs, strategic actions and current national and international guidelines for education and health"[32].

The interaction "of the student with health users and professionals" must occur throughout the course and interprofessional learning and interdisciplinarity must be provided, integrating the "biological, psychological, ethnic-racial, socioeconomic, cultural, environmental and educational dimensions" in the different scenarios of teaching, extension and research, which are inseparable[32].

The pedagogical approach must contain varied and interactive strategies that encourage student participation in the construction of their knowledge, associate theory with practice, stimulate curiosity, creativity, reflective practice, critical thinking and sensitivity, including, whenever possible, the humanities[32,59-62].

Practices should aim to incorporate knowledge, skills and attitudes (KSAs) with increasing complexity and have appreciation feedback for their improvement. The practical learning environment should be more controlled initially, such as, for instance, with role-playing or simulation in a communication laboratory, and progress to a less controlled environment, such as real-life scenarios, under supervision[59-62].

The assessment should be predominantly formative, without disregarding summative assessments[59-62].

The educational environment must be a safe one and cultivate ethics, sensitivity, empathy, solidarity, affection[74] and non-violent[75], inclusive and non-prejudiced communication, which makes medical training a model "from" and "for" the care that enhance the medical student's ability to establish respectful and constructive relationships in their process of learning and caring for themselves and others.

For this purpose, the institution must include the daily embracement of the student and the educator, listening to them and valuing their emotions, and it must contain structures for their psychological and pedagogical support. The problematization and critical reflection[76] of the socialization process must be carried out in a systematic and planned manner, for the development of the medical professional identity construction and the best use of the teaching-learning

process, aiming at attaining the objectives of the undergraduate medical course, which is to train competent, ethical, critical, solidary physicians, with social responsibility and committed to the defense of human dignity and social justice[32].

The hidden curriculum, characterized by witnessed attitudes and shared messages that are negative, ambiguous and not consistent with the objectives pursued by the course[77], must be the object of regular problematization and reflection in the formal curriculum. Based on praxis (reflection on practice), strategies must be developed to build a non-oppressive environment that encourages healthy relationships[78].

According to Bakhtin, we build ourselves in the interaction with other people[79], being the word the most pure and sensible form of the social relation and the communication the dynamic process for building social meanings. Language carries an ideology and a practice, and each "speech, statement or text expresses a multiplicity of voices, most of them without the speaker being aware of it"[2,79,80], which represent different interests and positions in the social structure. As what people "are or will become depends on a continuum of ruptures and transformations that occur as we interact with others"[2,79], disrespectful messages run the risk of being legitimized and incorporated by the student of medicine, especially when they are shared in a subtle manner[81], with derogatory gestures, jokes, images or comments. These strategies allow their disrespectful and unethical content to go unnoticed.

It is crucial that students and educators understand the ideologies that underlie the discourses about "the other", and that the hegemonic discourse in a given society is historically constructed through struggles, being socially shared in its different institutions (e.g., family and religious and educational institutions, which includes the medical school). It contains arbitrary criteria of classification, stratification and normativity regarding superiority/inferiority and inclusion/exclusion, which serve specific interests of power, privileges and/or prestige[82,83]. The non-perception of this arbitrariness is what makes them legitimate and perpetuated as common sense, generating multiple prejudiced interpretations such as classism, racism, sexism, machismo, capacitism, LGBTQIA+phobia and xenophobia[82-84], and other authoritarian and oppressive attitudes, of discrimination and intolerance. Based on the reflection, it is expected that people involved in the academic environment will increase their awareness of the values of professionalism to be cultivated.

To ensure the implementation and quality of communication teaching in medical schools, it is essential to *encourage and support faculty development* for the teaching of communication in institutional programs or in existing programs outside the institutions.

According to the DCNs, in its single paragraph of chapter II:

> *[…] competence is understood as the ability to mobilize knowledges, skills and attitudes, using the available resources, and expressing itself as initiatives and actions that will translate into performances capable of solving, with relevance, opportunity and success, the challenges that arise in professional practice, in different contexts of health work, translated into the excellence of medical practice, primarily in the scenarios of the Unified Health System (SUS).*

Therefore, we describe the KSAs to be developed throughout the course, described as *specific objectives* in Table 1. In it, the excerpts written between quotation marks are citations from the DCNs[32]. For certain specific purposes, relevant references are cited, which can help educators in the teaching of communication and physicians in their practice. For example, the "World Health Organization Patient Safety Curriculum Guide"[19], quoted several times, addresses: characteristics of effective communication; cultural competence; teamwork communication; safety of the person under care; conflict management; error management and disclosure; management of uncertainties; and, communicating difficult news, among other topics; and contains roadmaps for the safety of the person under care in procedures, emergencies, changes in work shifts, transfer between sectors and between institutions and for other communication topics, as well as documents, including informed consent and the form for the reporting of adverse events and errors.

We emphasize again, however, that the cited references are just a few among the vastness of the existing literature on communication.

Table 1. Specific communication objectives to be developed throughout the medical course in Brazilian medical schools

To develop competence in communication, throughout the medical course, the student must:
Become capable of communicating based on theoretical foundations, including
• theoretical frameworks and models of the Humanities, Social Sciences and Health on communication and human relationships, which include psychology and psychiatry;
• *scientific evidence on communication in health;*
• *principles and guidelines of the Unified Health System (SUS)[64] and public health policies*
• *professionalism and its components[52-56]*;
• history, culture, knowledges and practices of care and healing of the different social groups that constitute the Brazilian population;
• understanding of Metadiscourse, especially concerning the process of production, circulation and legitimation of the structured language and normative conventional beliefs that value or devalue certain social groups[85,86];
• concepts and characteristics of constructs related to intra- and interpersonal communication, such as emotional intelligence[87] and social skills[88];
• forms of expression of verbal and non-verbal communication and characteristics for their effectiveness[60,61,89,90];
• operational levels of verbal communication[86,91];
• pragmatic communication and its characteristics[92,93].
Search, critically evaluate the literature and prepare and write documents adequately, becoming able to
• recognize documents used in health care, medical education and health management; The documents include consultation files / physical and electronic medical records, exam request document, prescription, transfer report, discharge summary, reference and / or counter-reference form, compulsory notification, informed consent, living will, death certificate, notification of adverse events / errors, territorialization matrix/map, projects and documents for health education, reports and minutes in health care, among others; additionally, protocols, innovation and research projects, planning and resource management spreadsheets and health management contracts, among others; and, additionally, texts, narratives, reviews, scientific articles, abstracts, portfolios, presentations, extension and research projects in medical education, among others. ▪ write the documents, filling out the necessary fields, in a clear, structured and organized way, with coherence and cohesion, without redundancy or ambiguity, in legible handwriting (when written by hand), using correct Portuguese and appropriate medical technical terms, when relevant; ▪ include the name of the person in charge and, in health care documents, also the signature and stamp or digital certification of the professional; ▪ update information as soon as possible in registration documents.
• seek, organize and file information, with the help of information and communication; technologies (ICT), select relevant information through critical reading and prepare syntheses
• critically analyze the information posted on social media, identify false information and fake news and provide arguments about its untruth, based on evidence;
• develop research, extension and technological innovation projects with clear, structured, organized, coherent and cohesive writing, scientifically based and in correct Portuguese of the project, the Free and Informed Consent (FIC) form and/or Free and Informed Assent (FIA) form, of the partial and final report and of articles and abstracts;
• recognize that plagiarism is characterized as a crime of ideological falsehood.
Develop as a person (intrapersonal communication), with improvement of self-knowledge, adaptability, critical reflection and critical thinking, becoming capable of
• cultivate their own ▪ presence/mindfulness; ▪ empathy; ▪ resilience; ▪ creativity; ▪ curiosity and the ability to ask questions » in everyday life to reflect and broaden perspectives and understand relationships in complex situations;

Continues...

Table 1. Continuation

» to critically seek and evaluate scientifically-based information for clinical reasoning and responses to clinical situations; ▪ capacity to debate; ▪ assertiveness[19,26,27]; • recognize one's own emotions and emotional responses, and their influence on interpersonal relationships; • identify situations that may trigger strong emotions and anticipate contexts that may arouse them; • use strategies to manage their own emotions and seek support when needed; • promote and preserve one's physical and mental balance with self-care and self-compassion; • recognize signs of overload and changes in one's physical and mental health, including stress, anxiety, burnout and depression, seeking strategies to mitigate their causes and treat their diseases; • commit to learning to learn, to do, to be and to live together and develop progressive autonomy for learning; • recognize one's own strengths, limitations, desires, expectations, concerns, fears, prejudices and communication style and their influence on interpersonal relationships, strengthening potentialities and seeking strategies to overcome limitations; • demonstrate critical thinking; • demonstrate the capacity to debate; • identify one's prejudices and biases in clinical reasoning, which can affect the consultation and lead to diagnostic errors; • request feedback and receive it openly and flexibly to change one's knowledge and practices • reflect on the ethical / bioethical challenges experienced and witnessed, with ethical and legal principles as a reference; • reflect on shared messages and attitudes witnessed throughout the training, understanding the socio-historical aspects that perpetuate the hidden curriculum and the power relations and prejudices, identifying the values consistent with professionalism that must be incorporated into the construction of one's professional identity; • be co-responsible for ▪ promoting strategies to change messages and attitudes not consistent with professionalism; ▪ building an academic and work environment in health that promotes respect, ethics and sensitivity; • differentiate between simple and complex situations that lead to uncertainties; • deal with high levels of complexity and uncertainty, asking for support when necessary; • recognize one's limits in academic performance and health work and seek support when necessary.
Improve interpersonal communication, becoming able to
• express oneself in meetings and individual or group presentations, in an ethical, sensitive, respectful, inclusive and non-prejudiced manner (non-racist, non-sexist, non-capacitist, non-LGBTQIA+phobic, non-xenophobic, among others), appropriate for the age, level of schooling and other characteristics of the target audience, through ▪ clear, organized, logical, cohesive and coherent oral verbal communication, with an appropriate flow of information and balanced use of open and closed questions ▪ legible written verbal communication (when written by hand), organized, with a logical sequence, coherent, cohesive, without ambiguity or redundancy; ▪ nonverbal communication consistent with the verbal communication that shows respect and attention; » using ◦ written and/or illustrated educational resources (such as images, drawings, diagrams, three-dimensional models), artistic-cultural creative material and audiovisual resources in a balanced manner to motivate, improve the sensitivity and facilitate the understanding of participants; ◦ interactive strategies to maximize the participation of those who are interested when communicating with families, social groups and the community; ◦ maximize people's participation when their communication has limitations; » demonstrating ◦ mastery of the Portuguese language spoken in Brazil; ◦ mastery of medical technical terms used in the academic-scientific environment;

Continues...

Table 1. Continuation

- ◦ knowledge of the Brazilian Sign Language (LIBRAS, *Linguagem Brasileira de Sinais*) and other forms of inclusive communication, including alternative and extended communication (CAA, alternative and augmentative communication)[94-98] and support systems for people with alterations in expressive or receptive communication[97];
- ◦ knowledge of the language used in the different ethnicities and cultures of the Brazilian population and regions of Brazil ("communication geography");
- ◦ knowledge of at least one foreign language, ideally the one that most often conveys medical scientific information;

• adapt interpersonal communication to the method and channel / means of communication used, covering
  ▪ face-to-face communication;
  ▪ distance / virtual communication through ICT management, also considering
    » when communicating asynchronously,
      ◦ being careful when writing messages to avoid misinterpretation;
      ◦ a shorter presentation time;
    » when communicating synchronously, also considering
      ◦ the need for cultural sensitivity, encouraging dialogue, qualified listening, encouraging questions and the expression of concerns and fears, and an empathic and supportive response;
      ◦ technical, ethical and legal aspects of telehealth (teleconsultation / telecare) and other remote medical activities (telemedicine);
      ◦ the needs of the target audience and the characteristics of information to be conveyed in the media;
• building and maintaining rapport;
• perform qualified listening;
• recognize and demonstrate respect and sensitivity to cultural diversity and to values and other unique characteristics of each person;
• recognize verbal and non-verbal signals of emotions and respond with empathy and solidarity;
• deal with strong emotions, anticipating them when there are signs of tension, understanding their origin, managing one's own emotions, responding with sensitivity, empathy and solidarity and taking care of one's own safety, seeking help when they feel they may be at risk;
• provide respectful, constructive and appreciation feedback and accept feedback respectfully and with an openness to the change in attitudes and practices;
• understand and recognize factors that influence interpersonal relationships, including the phenomenon of transference and countertransference;
• recognize barriers and limitations that interfere with communication, consider the possibilities for their management, including their elimination, explain their existence and say that you will try to minimize their interference, search for interpreters or use other resources, including the CAA;
• *interact in a sensitive and respectful way and value the active participation of people who use CAA in the meeting;*
• *in research projects, explain the FIC and FIA forms to participants in an ethical, clear and honest way and interact respectfully and ethically with research participants when collecting information and validating their results;*
• *socialize knowledges in teaching, extension (including health care and health management activities) and in research;*
• *work in an interdisciplinary and interprofessional collaborative way as a member and a leader, with clear language and openness to "different opinions and respect for the diversity of values, roles and responsibilities"*[32] and, in health care[19];
  ▪ include the person under care, their family members and caregivers as part of the team[19];
  ▪ take responsibility for the person under care and the continuity of their care;
  ▪ subordinate one's own interests to those of the person under care and the team for shared decision-making;
  ▪ be responsible for the safety of the person under care, with special attention to processes with greater safety risk such as emergencies, procedures, changes in work shifts, transfers between sectors and institutions, relying on scripts and checklists to ensure effective communication[19,99];
  ▪ manage/mediate conflicts[19,99] with assertiveness and non-violent communication[75], aiming to
    » reach a consensus when there are differing opinions in teamwork;
    » address errors and behaviors that jeopardize the safety of the person under care;

Continues...

Table 1. Continuation

▪ when acting in leadership, additionally[19],
» contribute to the construction and strengthening of the bond and cohesion of the team and of a collaborative environment that promotes a "team spirit";
» agree with and clarify one's own role and function and that of other team members;
» coordinate and facilitate the rapid and regular flow of information relevant to teamwork
» encourage the sharing of ideas, perspectives and concerns, listening carefully to everyone and agreeing on decisions;
» provide appreciation feedback and request it on a regular basis;
» organize and coordinate meetings and keep up-to-date records;
» monitor the work situation, including psychological and social aspects that influence it and balance each member's workload;
» mobilize resources to enhance team performance;
» plan and organize team improvement/training activities.
Additionally, in health care, the student must become able to
• communicate in the different stages and processes of the clinical encounter at all levels, scenarios and processes of health care and dimensions of care, focusing on relationships and empowering people under care and their families / caregivers, as described in Figure 1;
The scenarios include the home, outpatient clinic/office, urgent/emergency care sectors, wards, intensive care unit and palliative care, surgery and recovery room, institutional therapeutic spaces, community spaces, institutions where people with certain characteristics and needs live, such as nursing homes and orphanages, among others.
The processes include consultation, embracement (both users receiving care on demand, and listening to them when referring to health services and actions), home visits, territorialization, exceptional therapeutic team project in contexts of vulnerability, matrix support (specialized technical support offered to the interprofessional team, to qualify their actions in health), coordination of health promotion groups, surgical and non-surgical procedures, health education, change of work shift, transfer of care between sectors and units, planning of advanced care, family talk and conference / medical report, risk communication and team meetings, among others.
▪ adapt the encounter and communication to
» age group [neonatal, infants, preschool and schoolchildren, adolescents, adults and the elderly];
» stage of the life cycle (from pregnancy and birth to aging and the dying process);
» specialty;
» cultural aspects, literacy, perspectives, needs, expectations and preferences of the person under care, their family members and/or caregivers;
▪ approach in a respectful, ethical and sensitive manner
» meetings with people under care and with families on home visits;
» the sexuality of the person under care, conducting the meeting according to their choices and needs;
» the experiences of the person under care regarding social, ethnic, racial and cultural aspects, knowing and recognizing their perspectives and values;
» spirituality, if the person under care so desires;
» people under care who have symptoms with no organic explanation, understanding their biopsychosocial context and their possible causes;
» people in situations of violence, including bullying, neglect and physical violence, dealing with their own emotions, responding with empathy and solidarity, empowering and promoting the autonomy of the person under care, and seeking psychological and social support and taking the necessary measures;
▪ build shared singular therapeutic projects, encouraging self-care and the "autonomy of individuals, families, groups and communities and recognizing users as active protagonists of their own health"[32];
▪ carry out matrix support activities, considering the knowledge of each team member;
• communicate in specific contexts (Figure 2), which encompass several processes, among them, but not exclusively,
▪ health risk situations to the person under care;

Continues...

Table 1. Continuation

- motivational interview, to identify the stage of behavioral change of the person under care, their degree of confidence and conviction to change, as well as the potentials and challenges perceived by them;
- change of habits according to the person's willingness to change;
- health risk behaviors, with their identification, approach when present and agreement on a therapeutic plan;
- management of uncertainties about the diagnosis, best therapeutic option, prognosis and other aspects of care, sharing them with sincerity and sensitivity to the person under care and to family members / caregivers and team members, demonstrating willingness to seek support for decision making, recognizing one's own emotions and responding with empathy to the emotions of the people present at that moment[19];
- difficult news[100-103];
- error / adverse event management, including[19]
  - » identifying areas prone to their occurrence;
  - » recognizing the ethical and legal issues related to its disclosure;
  - » meeting with the team and authorities involved to reflect and discuss what happened and why the adverse event happened, focusing on the task and not on the people;
  - » recording the adverse event in a specific form, with justification;
  - » planning measures to ensure that the mistakes that were made are not made again
  - » providing support to the team;
  - » disclosing the incident to the people under care, family members / caregivers and other people who respond for them in an ethical, respectful, sincere, objective way, without a defensive posture, demonstrating that one regrets what happened, recognizing the suffering it generated, sharing information and in clear language, without technical terms, following the process of communicating difficult news and explaining what happened and its causes, what is expected, the resources mobilized to support the affected people, how its investigation was and is being carried out and the measures being taken so that it does not occur in the future;
- crises, emergencies and disasters[104-111]
  - » act fast, effectively communicating with the health team, with responsibility for the safety of the person under care;
  - » plan and carry out risk communication for different audiences, recognizing and valuing the media as one of the main opportunities to communicate with the public, whose processes are well detailed in manuals and guides from international and national institutions[104-111];
  - » recognize signs of overload, stress and moral distress and seek support to deal with their consequences;
- intensive/critical care, with frequent sharing of information, in a respectful, empathetic and sincere manner
  - » with the person under care, to update them on their health conditions, keep them in contact with the external reality and encourage their participation in decision-making within their reach[112-114], using CAA[115,116], when they are intubated, tracheostomized or with other barriers and limited speech;
  - » with family members, caregivers and loved ones at a family conference / "medical report", preferably in a private place, encouraging their active participation in the meeting[117-119];
- palliative and end-of-life care, additionally[120-124],
  - » share information about health conditions and the lack of perspective of therapeutic cure in a sincere manner, using the steps for the communication of difficult news
  - » when there is a transfer to a palliative care unit, explain clearly and sincerely about its reason;
  - » talk about what the person under care wants to talk about or address, including their desires, their spirituality, information about the dying process, and other issues brought up by their families and/or loved ones;
  - » coordinate the planning of advanced care, together with the person under care, their families and/or loved ones and the members of the health team, agreeing on the place where they want to be cared for, the type of care they want to receive, if the situation gets worse, and record it;
- when asking about the intention to donate organs, demonstrate sensitivity and solidarity with the grieving process of family members/caregivers, responding to emotions with empathy, and showing respect and understanding when consent is denied[125,126];

• effectively communicate in processes and actions aimed at collective health[32], including

- health promotion groups;

Continues...

Table 1. Continuation

▪ "health diagnosis and problem prioritization [...] by investigating the health needs of groups of people and the living and health conditions of communities, identifying their risk and vulnerability based on "the political, cultural, institutional discrimination, socioeconomic, and environmental context and of the relationships, movements and values of populations in their territory" and on "biological, psychological, socioeconomic and cultural aspects related to illness and vulnerability" and the coping strategies[32]; ▪ "discussion and construction of intervention projects in social groups [...] always considering their autonomy and cultural aspects", encouraging the "inclusion of health promotion and education actions [...] and encouraging the "inclusion of perspective of other professionals and representatives of social segments involved in the creation of health projects"[32]; ▪ "development of plans directed at prioritized problems" and implementation of actions[32]; ▪ "planning and evaluation of projects and actions within the scope of the Unified Health System" [...] aimed at improving collective health[32].
Additionally, in health management, the student must become able to
• focus on relationships when organizing, monitoring and evaluating people and actions in health work and teaching-service integration;
• embrace users, families, social groups and the community, listening to their perspectives
• make decisions including listening to users, families, social groups, community and health team members;
• coordinate, create and implement intervention plans "together with users, social movements, health professionals, health sector managers and also from other sectors"[32];
• develop "scientific, technological and innovation development" projects, encouraging the participation and creativity of members of the interprofessional team(s) and the community[32];
• participate "in formal spaces for collective reflection on the work process [...] and intervention plans"[32];
• develop the diagnosis of the territory in a participatory way, together with the team professionals, local leaders and members of the community[32];
• disseminate the diagnosis of the territory among users, families, social groups, community and team members and agree with them on strategies to improve the reality[32];
• develop and/or participate in existing movements and projects to improve health and social conditions, at the local, regional, national and international levels[32].

Source: the authors

Table 2 provides some concepts and explanations of terms covered in this manuscript, to facilitate the readers' understanding.

Table 2. Explanations and details of some terms used in the manuscript

Term	Detailing
Assertiveness	Ability to share thoughts, perspectives, feelings and emotions in a respectful, calm, direct and sincere manner, defending personal and other people's rights, even asking for a change in behavior when perceiving the risks for them, with arguments based on facts and not on personal characteristics and without making value judgments, embarrassing, offending, humiliating or violating the rights of other people, remaining open and flexible to listen to everyone and sensitive to their feelings, dealing with one's own emotions and maintaining self-control[19,26,27]
External barriers to communication and intrapersonal limitations to communicating	Barriers that can be located in the physical environment, which include computer and sounds of appliances and equipment, among others; they can occur due to the use of protective equipment, which prevent the total or partial visualization of the meeting participants. They may result from the use of the virtual environment, with difficulty in access, internet instability, loss of visualization of the participants and impossibility of in-person approach. The limitations include: lack of mastery of the language spoken by the physician or by the person under care and caregivers, without the mediation of interpreters; early stage of neuropsychomotor development, with consequent lack of native language repertoire and social skills, as in the case of children; alterations in the neurological development, resulting in cognitive impairment and global developmental disorders, which also impair social interactions (such as autism spectrum disorders); auditory sensory alteration not mediated by an interpreter; visual sensory alteration that prevents the reading of documents such as the prescription; diseases of neurological, neuromuscular or oncological origin that cause dysphasia, aphasia, cognitive impairment or limitation of motor movement responsible for speech, including stroke, brain injuries, dementia, locked-in syndrome, head and neck cancer, Parkinson's disease and Amyotrophic Lateral Sclerosis, among others; and, situations that generate the transient impossibility of speaking, such as ventilatory support and tracheostomy, among others; psychiatric disorders and alterations in mental status due to intoxication by psychoactive substances
Alternative and augmentative Communication (CAA)	Diversity of linguistic resources (communication systems) with the aim of mediating, supplementing and/or facilitating interactions between people with impaired oral, gestural and/or written communication, of physical, mental, intellectual or sensory origin. It allows the person's social participation and the sharing of their emotions, perspectives and desires. It tends to improve motor, cognitive and affective development with improved self-esteem, self-confidence and empathy. Extended communication complements the existing speech, and its users have difficulties in speaking and understanding language. In the alternative communication, speech is non-existent or non-functional and its users have a cognitive understanding of language, but have difficulty speaking, and it can be permanent or temporary due to interventions such as intubation and tracheostomy. CAA can be non-assistive (unsupported), when only the human body is used to communicate, or assistive, when it depends on resources that are external to the body. Resources with no or low technology include communication by written and sign language, by gestures, facial expressions, alphabet boards or pictographic symbols, among others. High-tech resources include mobile devices, voice communicators, computers, tablets and software with programmable functions, which convert text into natural sounds and symbols, according to the user's needs. They use a variety of methods to detect human signals generated by body movements, such as image sensors activated by eye tracking and head signals, mechanical and electromechanical sensors activated by mechanical boards and switch access to use the computer screen, touch-activated sensors such as touchscreens, breath-activated sensors by microphones and low-pressure sensors, and sensors with invasive or non-invasive brain-computer interface[94-98].
Support systems for people with expressive or receptive communication disorders	Support systems for people with expressive or receptive communication disorders include expanded additional support, and assistive hearing technology systems. They include Braille, hearing amplification through hearing aids, cochlear implants and assistive hearing technology systems (such as personal amplification devices via text telephones and telecommunication devices for the deaf); and, artificial phonation devices and voice amplifiers, such as intraoral devices and valves for speech (as used in people with tracheostomy, for instance)[97].
Non-violent communication	It aims at maintaining peaceful everyday interactions, cultivating self-awareness and self-compassion, and honoring one's own needs and values and the needs and values of others. Its process includes observing and listening attentively to others without judgment, reflection to identify one's feelings in relation to what is observed and the recognition of the personal needs, values and desires that generate these feelings, confirmation of the understanding about what the other person speaks, paraphrasing to check for accuracy, using specific words to express feelings and emotions rather than unclear words, making requests clearly and specifically without demanding their fulfillment, being empathetic, understanding, and compassionate when they are refused, respecting the person's choice to do something or comply with our request of their own free will[75].

Continues...

Table 2. Explanations and details of some terms used in the manuscript

Pragmatic communication	Ability to use language in context and to understand and express the basic meanings of words (semantics) with correct grammatical forms (syntax). Its characteristics include providing information that is appropriate to the needs of those who receive it, expressing perspectives and ideas in a logical and coherent sequence, sharing problems and monitoring the adequacy of the production of one's own speech in a specific context, among others[92,93].
Verbal and non-verbal communication	Verbal communication expresses the word, either orally or in written/typed form. Non-verbal communication encompasses all other forms of communication that do not represent the word, but influence its interpretation, such as paralanguage (tone, intensity, rhythm, volume and sounds that are not words like "Uh huh"), kinesics (body movements, including gestures, posture, head movements, facial expressions, way of looking, among others) and proxemics (how people perceive and use interpersonal space), among others[60,61,89,90].
Disaster	Serious disturbance in the function of a community or society, due to the interaction between hazardous events and conditions of exposure, vulnerability and capacity, which results in human, material, economic and/or environmental losses and impacts. It can have a natural origin (meteorological and hydrological, extraterrestrial and/or geological), biological (such as epidemics and pandemics) and/or anthropogenic (technological, chemical, social and environmental). It is currently considered that all disasters are mixed, due to the interdependence between these phenomena[110,111].
Social skills	Specific behaviors in specific contexts in a given social environment, to interrelate and complete social tasks. The main classes of social skills include: communication, civility, making and maintaining friendships, empathy, assertive skills, expressing solidarity, managing conflicts and resolving interpersonal problems, expressing affection and intimacy, coordinating groups, and public speaking[88].
Emotional Intelligence	Ability to understand oneself, including one's own emotions, fears, feelings and motivations, and to understand other people's emotions, motivations and expectations, which can be categorized into five domains: emotional self-knowledge, emotional control, self-motivation, recognition of emotions in other people and social skills for interpersonal relationships. The last two are crucial for group organization and leadership, conflict management and solution agreement, empathy and social sensitivity[87].
Idiom	System of codes with rules that allow the communication between certain social groups[1].
Language	According to the Houaiss[1] dictionary, on page 1763: "1. Any systematic means of communicating ideas or feelings through conventional signs, sound, graphics, gestures, etc. [...]".
Metadiscourse	Discourse function through the analysis of how signs are designed to influence meanings and attitudes[85,86].
Operational levels of verbal communication	They include three levels. One of them is concrete, which is the denotative level, related to the content. Two of them are more subjective; the metalinguistic one, related to the type of language used, and metacommunication one, related to the interpretation of the received messages, mainly through implicit messages of non-verbal signals, but also, more rarely, by explicit verbal ones[86,91].
Information and communication technologies (ICT)	Set of integrated technological resources to process information and assist in communication. They cover all forms of transmission of information and technologies that interfere and intervene in information and communication processes between human beings. It can be performed through computers, tablets, cell phones, software and telecommunications. The exchange of information can occur in a virtual synchronous way, with tools such as, for example, telephones, virtual platforms, WhatsApp and other applications; and, asynchronously, with tools such as e-mail messages, text messaging applications such as SMS, virtual platforms, websites, television, radio, among others. Their use in health care includes several activities, including, but not limited to, videoconferences, consultations, virtual procedures, filling out medical records and electronic forms, sharing of messages, exams, data and other documents.

Figure 1 illustrates the different stages and processes of the relationship-centered encounter.

Figure 2 illustrates specific contexts in which the medical student must acquire the ability to communicate in health care, represented by a tree. Its trunk represents communication centered on relationships, its base represents its support by professionalism[52-56], the SUS[64], the DCNs[32] and theoretical references and scientific evidence, by which it must be guided or on which it must be grounded, and its canopy cover contains the contexts for the teaching of communication in health care.

Figure 1. Communication centered on relationships in the different stages and processes of the clinical encountera

COMMUNICATION DURING THE ENTIRE MEETING

- **Attitudes** of professionalism, including respect for the "biological, subjective, ethnic-racial, gender, sexual orientation, socioeconomic, political, environmental, cultural diversity", literacy, choices and preferences and "other aspects" "that singularize each person or [...] social group", ethics, confidentiality, support for autonomy and responsibility for security
- **Construction and maintenance of the rapport** by demonstrating cordiality, sensitivity, affectiveness, listening carefully to nonverbal signs of emotions, questioning if they are not expressed, acceptance of crying and solidarity and empathic response, communicating perception about them, legitimizing them, showing respect, support, partnership and that they care and want to help; use of verbal, nonverbal and silence communication appropriately; reflection on their own emotions and reactions, and their influence on the relationship
- **Organization**: in the communication, attention to the flow, time management and layout of furniture and papers on the table
- **Timely sharing of information**, in clear, understandable language, without technical terms, with little information at a time, written and/or illustrated resources (images, diagrams, drawings and three-dimensional models), if possible, to facilitate understanding, frequent summaries to verify mutual understanding, identification of what the person under care and caregivers already know, what they want to know, requesting synthesis to verify understanding and provide additional explanations, if necessary
- **Recording of information** in medical records / files and other documents, with the **filling out** of all required fields and **written** in an organized, legible manner, if handwritten, and identification, stamp and signature / digital certification, and explanation with additional written and / or illustrated resources, whenever possible
- **Encouraging the active participation of the person under care and caregivers** with open questions, attentive listening of perspectives, preferences and decisions

COMMUNICATION IN THE DIFFERENT PHASES OF THE ENCOUNTER

1. Start of the meeting

1.a. Initial construction of the rapport

- ✓ Cordial reception to all, with greetings and presentations
- ✓ Care about comfort and make everyone feel at ease
- ✓ Social conversation, when relevant for relaxed atmosphere
- ✓ Recognition of barriers to communication (e.g.: computer, sounds, mask) and explanation that will try to minimize it

1.b. Agreement on the "agenda" of the person under care and the physician

- ✓ Question about reasons for seeking medical attention
- ✓ Listening, no interruptions or value judgment
- ✓ Encouraging to speak, asking "anything else? " until nothing else is added
- ✓ Synthesis of spoken causes/problems
- ✓ Explanation of aspects one also wants to address
- ✓ Agreement of meeting priorities, based on the demands of both

2. Obtaining the biopsychosocial, cultural, spiritual and contextual history

- ✓ Open questions about life history, illnesses and perspectives about their causes and consequences, what they have already done, values, beliefs, concerns, needs, fears and other feelings, preferences and expectations
- ✓ Attentive listening, without interruption and with appreciation and legitimization of speech
- ✓ Attention to emotions and empathic response
- ✓ Frequent summaries
- ✓ Explanation about the transition to more specific closed issues
- ✓ Biomedical and other closed questions relevant to clinical reasoning

3. Explanation about the transition to physical examination and consent request

4. Physical examination and clarification of procedures and findings as one performs them

5. Sharing information and encouraging participation, considering reported perspectives, needs and concerns and what they already know and want to know about:

- ✓ diagnostic findings and possibilities, necessary investigation and their reasons
- ✓ objectives, therapeutic options and procedures, taking into account the practices of care and cure reported by the person under care and their choice not to be treated, expected response and duration, benefits, risks, potential outcomes that may affect their physical and mental health, uncertainties, costs, probable prognosis and availability of medications and services

6. Shared construction of therapeutic plan

- ✓ Encouraging active participation in decision-making
- ✓ Identification of desired level for involvement in decision making and social and psychological resources needed for their support
- ✓ Identification of values for choices, supporting autonomy
- ✓ Conflict mediation and conciliation of divergent views
- ✓ Evaluation of facilitators and challenges/barriers to adhere to possible plans
- ✓ Joint search for strategies to deal with challenges
- ✓ Agreement of therapeutic plan and verification of understanding
- ✓ Writing of the plan and documents, including request for examinations, prescription, recommendations and referrals, and their explanation, preferably with additional resources

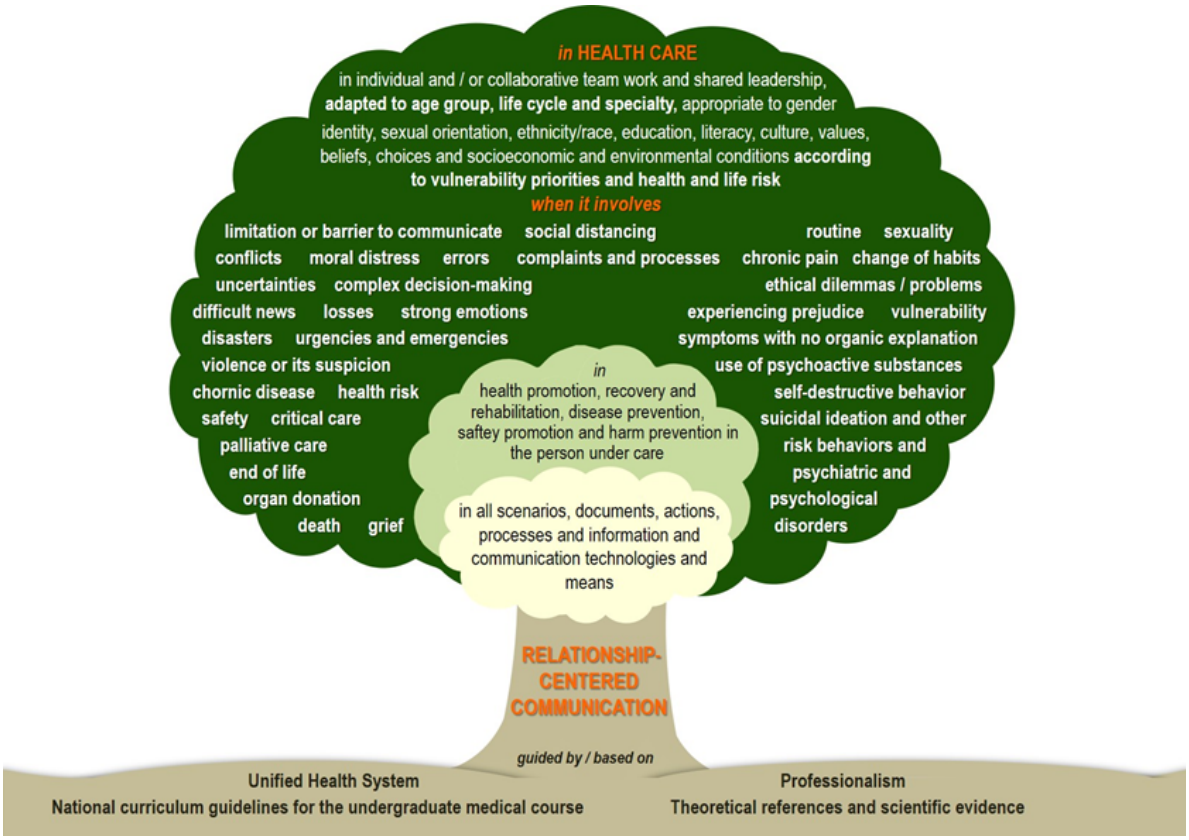
7. Closing of the encounter

- ✓ Request for summary on agreed plan and additional explanations, if necessary
- ✓ Scheduling the return consultation and providing contacts, if appropriate
- ✓ Farewell

Source: the authors

[a] The excerpts between quotation marks are quotes from the National Curricular Guidelines for the undergraduate medical course[32] and the model was based on the literature[38-42,60].

Figure 2. Health care contexts in which the medical student must acquire the ability to communicate



Source: the authors.

FINAL CONSIDERATIONS

This is the first consensus for the teaching of communication in Brazilian medical schools. We emphasize, however, that it represents an initial step and that, due to its collective and collaborative construction with representatives from more than half of the medical schools and other areas of health and representatives of health institutions, the consensus must be seen as a process of ongoing construction, which may require additions in the future.

It is assumed that communication should be centered on relationships, based on professionalism, universality, integrality and equity in health care for the population and encourage social participation, and based on the DCNs, theoretical references and scientific evidence. Specific objectives are described to develop competence in communication in the medical graduate, covering the theoretical foundations, the search, critical evaluation of the literature, preparation and writing of documents, and intrapersonal and interpersonal communication to make the medical graduate competent in communicating with people involved in the academic-scientific environment and in health care and health management. It is recommended the inclusion of communication in the curriculum from the beginning to the end of the course, integrated with other contents and areas of knowledge.

The moments in which each objective must be developed in the course were not established, considering the peculiarities of the curriculum of each school and their autonomy in its planning.

We hope the consensus will contribute to the review of curricula of undergraduate courses in medicine that already contain communication or to its implementation, and, perhaps, in the curricula of medical residencies in Brazil, to promote communication in medical education, in the attention to individual and collective health and in health management, to strengthen the SUS and achieve social transformations that improve the population's health conditions and the defense of social justice.

The next objective of this ABEM project is to offer teaching materials and workshops to support teacher development in the teaching of communication.

Finally, we clarify that, just like any collective construction process, this consensus can be updated when necessary.

AUTHORS' CONTRIBUTION

Suely Grosseman is the coordinator of the project "Teaching communication in schools in the health area" of the Brazilian Association of Medical Education, of the process of collective consensus construction and the writing of this manuscript; Newton Key Hokama organized and maintained the virtual group under regular activity to discuss the consensus and share knowledges and experiences on communication and contributed to the writing of this manuscript; Evelin Massae Ogatta Muraguchi reported on the consensus construction workshops and participated in the review of this manuscript; Ana Cristina Franzoi synthesized the existing consensuses to support the discussion of the current consensus and contributed to the writing of this manuscript; Gustavo Antonio Raimondi contributed with additions on inclusive communication to the consensus and in the final review of this manuscript; Agnes de Fátima Pereira Cruvinel, Eliane Perlatto Moura, Fernanda Patrícia Soares Souto Novaes, Josemar de Almeida Moura, Lara de Araújo Torreão, Maria Amélia Dias Pereira, Mônica da Cunha Oliveira and Rosana Alves contributed to the construction of the consensus and the writing and final review of this manuscript.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest related to this study.

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LIST OF ALL CONSENSUS' PARTICIPANTS WHO AGREED TO THE DISCLOSURE OF THEIR NAMES AND INSTITUTIONS

Suely Grosseman (ABEM project coordinator)

Facilitators: Newton Key Hokama (coordinator of the virtual communication group WebComunica Brasil) and Evelin Massae Ogatta Muraguchi (reporting of the consensus workshops)

CEOs of the ABEM administrations that supported the project: Jadete Barbosa Lampert, Sigisfredo Luis Brenelli and Nildo Alves Batista

Ádala Nayana de Sousa Mata - Escola Multicampi de Ciências Médicas do Rio Grande do Norte /Universidade Federal do Rio Grande do Norte

Agnes de Fátima Pereira Cruvinel - Universidade Federal da Fronteira Sul

Alessandra Vitorino Naghettini - Universidade Federal de Goiás

Alice Mendes Duarte - Universidade Federal do Rio Grande do Norte

Alicia Navarro de Souza - Universidade Federal do Rio de Janeiro

Ana Cristina Franzoi - Universidade Federal do Rio de Janeiro

Ana Paula Mariussi - Universidade da Região de Joinville

Cacilda Andrade de Sá - Universidade Federal de Juiz de Fora

Cáthia Costa Carvalho Rabelo - Faculdade de Ciências Médicas de Minas Gerais e Santa Casa de Minas Gerais

Cecilia Emília De Oliveira Creste - Universidade do Oeste Paulista

Danielle Bivanco-Lima - Faculdade de Ciências Médicas da Santa Casa de São Paulo

David Araujo Júnior - Universidade Federal de Uberlândia

Denise Herdy Afonso - Universidade Estadual do Rio de Janeiro

Dolores Gonzales Borges de Araújo - Escola Bahiana de Medicina e Saúde Pública

Elaine Fernanda Dornelas de Souza - Universidade do Oeste Paulista

Eleusa Gallo Rosenburg - Universidade Federal de Uberlândia

Eliane Perlatto Moura - Universidade João do Rosário Vellano

Eloisa Grosseman – Universidade do Estado do Rio de Janeiro

Erotildes Maria Leal – Universidade Federal do Rio de Janeiro

Evelin Massae Ogatta Muraguchi - Pontifícia Universidade Católica do Paraná, Campus Londrina

Fernanda Patrícia Soares Souto Novaes - Universidade Federal do Vale do São Francisco

Guilherme Antonio Moreira de Barros - Universidade Estadual Paulista

Gustavo Antonio Raimondi – Universidade Federal de Uberlândia

Helena Borges Martins da Silva Paro - Universidade Federal de Uberlândia

Hermila Tavares Vilar Guedes - Universidade do Estado da Bahia

Iago Amado Peres Gualda - Universidade Estadual de Maringá

Ilza Martha de Souza - Universidade do Oeste Paulista

Irani Ferreira da Silva Gerab - Universidade Federal de São Paulo

Ivana Lucia Damásio Moutinho - Universidade Federal de Juiz de Fora

João Carlos da Silva Bizario - Faculdade de Medicina de Olinda

José Maria Peixoto - Universidade João do Rosário Vellano

Josemar de Almeida Moura - Universidade Federal de Minas Gerais

Juliana Guerra - Faculdade Pernambucana de Saúde

Lara de Araújo Torreão - Universidade Federal da Bahia

Lara Cristina Leite Guimarães Machado - Universidade da Região de Joinville

Laura Bechara Secchin - Faculdade de Ciências Médicas e da Saúde de Juiz de Fora

Leandro Francisco Moraes Loures - Universidade da Região de Joinville

Liliane Pereira Braga - Universidade Federal do Rio Grande do Norte

Luiza De Oliveira Kruschewsky Ribeiro - Escola Bahiana de Medicina e Saúde Pública

Marcela Dohms – Vice-presidente da Associação Brasileira Balint

Márcia Helena Fávero de Souza - Universidade Federal de Juiz de Fora

Maria Amélia Dias Pereira - Universidade Federal de Goiás

Maria de Fátima Aveiro Colares - Centro Universitário Municipal de Franca

Maria Eugenia V. Franco - Universidade Federal do Mato Grosso

Maria Luísa Soliani - Escola Bahiana de Medicina e Saúde Pública

Maria Viviane Lisboa de Vasconcelos - Universidade Federal de Alagoas

Mariana Maciel Nepomuceno - Universidade Federal de Pernambuco

Marianne Regina Araújo Sabino - Faculdade de Ciências Médicas de Pernambuco

Marta Silva Menezes - Escola Bahiana de Medicina e Saúde Pública

Mauricio Abreu Pinto Peixoto - Instituto Nutes da Universidade Federal do Rio de Janeiro

Milene Soares Agreli - Universidade Federal de Uberlândia

Miriam May Philippi - Centro Universitário de Brasília

Mônica da Cunha Oliveira - Escola Bahiana de Medicina e Saúde Pública

Mônica Daltro - Escola Bahiana de Medicina e Saúde Pública

Newton Key Hokama - Universidade do Estado de São Paulo, Botucatu

Nilva Galli - Universidade do Oeste Paulista

Paulo Pinho – Universidade do Estado do Rio de Janeiro

Paulo Roberto Cardoso Consoni - Universidade Luterana do Brasil

Priscila Maria Alvares Usevicius - Universidade Evangélica de Goiás

Renata Rodrigues Catani - Universidade Federal de Uberlândia

Rosana Alves- Faculdades Pequeno Príncipe

Rosuita Fratari Bonito - Faculdade do Trabalho de Uberlândia

Sandra Torres Serra - Universidade Estadual do Rio de Janeiro

Simone Appenzeller - Universidade Estadual de Campinas

Simone da Nóbrega Tomaz Moreira - Universidade Federal do Rio Grande do Norte

Solange de Azevedo Mello Coutinho - Escola de Medicina Souza Marques

Suely Grosseman - Universidade Federal de Santa Catarina e Faculdades Pequeno Príncipe

Ubirajara João Picanço de Miranda Junior - Escola Superior de Ciências da Saúde

Valéria Goes – Universidade Federal do Ceará