interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Debates
Medical education and gender violence

Are we preparing future doctors for assistance in situations of violence with a focus on gender and non-heterosexual sexualities? Report of a diagnostic educational "experience"

Estamos preparando os futuros médicos para atendimentos de situações de violência com enfoque em gênero e em sexualidades não heterossexuais? Relato de uma "experiência" educacional diagnóstica (resumo: p. 17)

¿Estamos preparando a los futuros médicos para la atención de situaciones de violencia con enfoque en género y en sexualidad no heterosexuales? Relato de una "experiencia" educativa diagnóstica (resumen: p. 17)

Beatriz Angélica Cruz[a]
<beacruz.19@gmail.com>

Ana Flávia Azevedo Querichelli[b]
<aquerichelli@yahoo.com.br>

Lucas Uback[c]
<luuback@hotmail.com>

[a, b, c] Médicos. São José do Rio Preto, SP, Brasil.

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Abstract

Medical schools must incorporate the teaching of professionalism into the curriculum to ensure that the next generations of physicians are prepared for a compassionate, humane, and ethical professional practice, suitable to the interests of society in a world with ever-increasing and ever-changing demands. This study's greatest contribution is to highlight the interns' poor performance in the legal and support aspects of the situations addressed. The data speak in favor of an institutionalized training policy as the first step toward getting the healthcare sector to prioritize competence in healthcare for victims of violence related to gender and non-heterosexual sexuality.

Keywords: Education, medical. Delivery of health care. Sexuality. Gender identity. Clinical competence.

Cruz BA, Querichelli AFQ, Uback L, Lima ARA, André JC. Are we preparing future doctors for assistance in situations of violence with a focus on gender and non-heterosexual sexualities? Report of a diagnostic educational "experience". Interface (Botucatu). 2023; 27: e220098
https://doi.org/10.1590/interface.220098

Introduction

Medicine has lost the subjective elements of communication between the physician and the patient, focusing only on technical instrumentation and data objectivity[1]. Studies show that, in Brazil, medical students and physicians do not encourage patients to develop autonomy, and are not prepared to deal with their patients' emotional problems, especially due to their hegemonic medical training that focused solely on biomedical aspects[2].Even though evaluations about the doctor–patient relationship show scores that equate Brazilian medical students with North American students, and score them more highly than the scores of other non-American students in this sample[3], indicating their concern with care, Brazilian medical students are still not very willing to talk with patients about the patients' own healthcare priorities, or learn their knowledge or beliefs about the health–disease process[2]. Therefore, there is a need to rescue values such as democracy, ethics, critical capacity, and autonomy in medicine, making it more humane and more capable of considering the complexity, richness, and potential of human beings[4].In this sense, the medical student's code of ethics recommends demonstrating respect and dedication to the patient, never forgetting their humanity, in addition to helping them as much as possible (and as reasonable) with regard to personal problems, considering them as an individual being inserted in a unique cultural environment[4].

Medical schools must incorporate the teaching of professionalism into the curriculum to ensure that the next generations of physicians are prepared for a compassionate, humanistic, and ethical professional practice, suitable to the interests of society in a world with ever-increasing and ever-transforming demands[5]. Advances in developing the teaching of medical professionalism in undergraduate courses depend, in many situations, on a change of focus, on establishing priorities in education, and on a reflective posture in relation to current academic practices by the health professionals who are directing the educational process[6]. The trajectory of focus changes in medical education -where the structure progressed from information to training and, later, to transformation - translates the need to rethink the undergraduate medical curriculum, aiming at greater ethical sensitivity and social responsibility[7].

In this sense, it is important to discuss the hegemonic models that influence values, interests, discourses, knowledge, and practices such as professionalism, throughout medical training. For this, debate around concepts/actions such as identity, diversity, inclusion, hegemony, ideology, power, and culture, as well as the values desirable for a true professional, is fundamental. Such debate can occur in a longitudinal and integrated way in curricular units related to the humanities, in the professional–user relationship, in interdisciplinary studies, in the social sciences, and in psychology, among other contexts[8].

Communication skills (CS) expected from physicians and, consequently, from "almost-physicians" (clerkships), include data collection techniques during the interview, explanations given to the patient, care planning discussions, as well as obtaining consent to perform procedures. Despite the growing appreciation of CS in medical training, there is still no consensus on what "adequate" doctor–patient communication is. CS assessment methods should cover different aspects, such as

empathy, interview organization, voice intonation, and non-verbal language[9].This raises questions such as: 1) Have CS been taught and evaluated during the process of training students and professionals in the health domain in Brazil?; 2) What instruments have been used?; and 3) What advances in the evaluation process of this competence are still needed in the country?[10] It is important to emphasize that the establishment of a bond is essential in creating an environment where it is possible to provide the necessary guidelines - ones that go beyond the issue of the moment, a facilitator to work with several issues - such as those related to treatment and medication adherence, meeting the Brazilian National Health System's (SUS) principles and the expanded concept of health, and offering healthcare aimed at preventing complications and promoting health, as recommended by the Primary Healthcare Policy[11].

In a humanistic and professional context, empathy is important in the doctor–patient relationship. Patients reveal their complaints and concerns more completely, which results in a better diagnosis and treatment. However, physicians today are afraid that, by being empathic, they may lose their discernment and judgment or may suffer with the patients, so physicians distance themselves from them. This challenge can be overcome if physicians recognize and reflecting on their own emotions, fostering constructive and elevated feelings that will result in professionalism and ethical and humane behavior[12].The role of medical professors and preceptors is notorious in discouraging the development of empathy in medical students, directly interfering in the conduct of future physicians. Therefore, important actions in medicine courses must be implemented with a view to developing increased empathy in medical professors and preceptors, whose training and behavior will have direct implications for the medical student[13].

Considering that sexuality is an inalienable part of human existence, dealing with its complexity is an attribute expected from the physician. There are few publications on the teaching of human sexuality in medical curricula, with a tendency to approach it through the subjects of gynecology, psychiatry, or urology[14], reducing the theme to purely biological aspects of the health–disease process[15]. This is why students say they do not have the skills to address topics such as sexual pleasure, or to conduct care in situations of sexual and gender violence, demonstrating unpreparedness to provide emotional, technical, and legal assistance - a reflection of deficient training[16].

In addition, heterosexuality is the sexual orientation most valued by most professors[16], which becomes "normative" for both sexual relations and lifestyle, legitimizing a hierarchy of sexual value by defining what is sexually normal, natural, and healthy, opening the door to discrimination and hostility against people with variant sexualities[14]. This view creates stress and inhibits open communication in non-heterosexual patients in medical appointments, which can lead to treatment delay or discontinuation and subsequent complications[14]. Reports show that transgender patients experience hostile, cold, and rejecting behavior from health professionals; that lesbian women receive non-empathic responses when they talk about their sexual identity, and feel at risk while consulting with health professionals; and that gay men have the perception that the service was homophobic[14]. In turn, many physicians are uncomfortable working with lesbian, gay, bisexual, and transgender (LGBT) patients because their education did not prepare them to deal with violence directed against this population[16].

The current Brazilian historical moment is marked by the political rise of radical right-wing parties and the systematic withdrawal of human rights[15].This must be understood in light of the 2008 crisis in its structural, chronic, and cumulative aspects[17]. In this sense, the conservative ideology must be highlighted, in that it guides institutional reforms, public policies, and the daily behavior of the population. This happens partly because, having the family as its reference, the conservative view sees social issues as being derived from moral issues. This posture contributes to the reproduction of prejudice, transforming morality into moralism, and consolidating it through violence[18].

In the symbolic field, violence operates mainly in the normalization processes. The hegemonic heteronormative ideology is inculcated in them, drowning subjectivities by celebrating as "correct" only one type of sexuality, to the detriment of so many others - real, albeit "deviant"[19]. In the physical-material field, violence translates into physical aggression and precariousness. The Gay Group of Bahia[20] reports 420 deaths in the LGBT population in 2018 that were motivated by homofobia - 320 homicides (76%) and 100 suicides (24%). Likewise, the precariousness of the lives of "deviant" people operates in a multiplicity of actions, expressed in the asymmetry of salaries and jobs, and in the access to goods, public and private services, and geographic spaces[21].

Thus, the role of the SUS in Brazil is highlighted as a potential field for the articulation and implementation of health policies and actions that include sexuality and gender as determinants of the health–disease process, and aim to overcome forms of discrimination and social exclusion[22]. In the articulation of the doctrinal principles (integrality, equity, and universality), legal basis, social participation, and pressure from the LGBT community, the Ministry of Health implemented the National Policy on Comprehensive Health for Lesbians, Gays, Bisexuals, and Transgender People through Ordinance No. 2836 of 2011. Despite this, there is a serious mismatch between the enactment of these and other policies aimed at the LGBT population and their daily implementation, which means insecurity for this population, given the fragility of democratic instruments available in the Brazilian reality and the growing commitment to the principle of a secular state[23].

The analysis of sexuality teaching in medical courses clearly shows that the quality of sexual health care also depends on training that involves all aspects of sexuality in a broad and not merely biological way[24]; however, there are no elements of medical education in Brazil that contribute to health promotion in this population segment, which is why there is an urgent need to enact the national LGBT health policy as an effective tool to promote human rights among medical professionals, from school to professional practice[25]. The national policy for comprehensive LGBT health presents, in its operative plan, the "need to identify the health needs of lesbians, gays, bisexuals, transvestites, and transsexuals, and use them as a criterion for planning and setting priorities"[26]. However, despite proposing a discussion of the health needs of the LGBT population from the perspective of the social determination of the health–illness–care process, it still makes explicit, in its text, several health needs grounded in the medical-scientific discourse[27].

The assessment of professionalism in medical students through domains such as altruism, responsibility, care, and teamwork is frequent and can use scenarios or simulated patients, online quizzes, or applications[28].

Performance evaluation in a simulated environment is widely used in medical training. Of the available methods, the Objective Structured Clinical Examination (OSCE) is the most used at both undergraduate and graduate levels. As it is standardized and uses multiple examiners, it is considered a fairer assessment and can be either formative or summative[10,29].

The OSCE was developed due to the need and difficulty in analyzing some skills, such as clinical skills, knowledge, attitude, communication, and professionalism, and was standardized to be a reliable tool. It is one of the gold standard tests to assess medical skills, as it is not restricted to knowledge, but also to the student's ability to practice it[29]. In addition to evaluating anamnesis, physical examinations, and the interpretation of clinical results, it also evaluates the effectiveness of communication, including situations involving ethical dilemmas. The OSCE stations should be as close to reality as possible to have greater relevance for students, especially in situations that involve subjective elements such as communication and feelings.

This study is relevant because nationally, medical action on sexuality issues is limited, rarely providing comprehensive and humane care in situations of sexual violence and general health for the LGBT population[16]. Medical curricula in Brazil must recognize this theme, understand its relevance for medical training and its complexity, and use its historical, political, and cultural aspects to develop effective intervention strategies to improve the quality of comprehensive healthcare for the LGBT population[30]. The study assessed the contribution of a public medical course in São Paulo, Brazil, for the development of professionalism in its "almost-professionals" (clerkships) regarding sexuality and gender identity issues.

Considering that the high standard of patient care in Brazil and worldwide are based on comprehensive and humane care; that there are problems around the world to meet these standards, given the hegemonic models that influence values, interests, discourses, knowledge, and practices throughout medical training; that in the Brazilian context, despite an established national policy, there are difficulties in developing effective intervention strategies in the reception and quality of comprehensive healthcare for the population that is vulnerable due to gender and sexuality issues; and that the gaps and potentialities extant in the literature on the training process of future medical professionals in situations of violence focused on gender and non-heterosexual sexualities, this study aimed to answer the question: Are the clerkships (the "almost-professionals") of School Faculdade de Medicina de São José do Rio Preto - FAMERP - typical students of Brazilian medical schools - able to provide healthcare that encompasses situations of violence focused on gender and non-heterosexual sexualities?

An informal diagnostic assessment ("experience") make the teaching/learning process more efficient and effective by zeroing in on content that needs to be taught and mastered. Therefore, it was pertinent to carry out this diagnostic educational "experience", reported below, with a view to evaluating the contribution of a public Medicine course from São Paulo state countryside, Brazil, as it is currently structured,

for the development of the professionalism of its quasi-professionals (clerkships), in the questions of sexuality and gender identity, making use of the OSCE.

Methodology

Research in the exploratory modality that problematizes its object of study, bringing it to light so that it can be the target of future research; with an analytical and observational objective in which a diagnostic educational "experience" was observed, recorded, analyzed, classified and interpreted; with a qualitative approach, since the statistical methods were dispensed here, considering that the focus was on the results of the diagnostic educational "experience" and whose analysis of the information collected was carried out by the researchers who performed subjective interpretations when classifying the performances as satisfactory (S), partially satisfactory (PS) and unsatisfactory (I), with the objective of providing subsidies to raise the discussion about the competence for patient care in situations of violence with a focus on gender and non-heterosexual sexualities; case study nuance when considering observations about the phenomenon observed in diagnostic educational "experience".

The diagnostic educational "experience" was carried out as part of a scientific initiation project developed at the institution, as a result of a workshop promoted at the institution dealing with this theme. The study subjects were students in their fifth and sixth years of medical school (clerkships) at Faculdade de Medicina de São José do Rio Preto - FAMERP, in January and February 2020 - a period of the academic year when students have their regular academic routines and are not taking any exams - who received a link with an invitation, an informed consent form (ICF), and an electronic form to express their participation in the OSCE (inclusion criteria). 158 students were invited. In this institution, the curriculum is considered "traditional", serial and divided into basic, clinical and intership cycles.

The number of stations depended on the number of evaluators and actors available for the process. There were two evaluators, and two simulated patients who were individuals experienced in acting or the arts.

Each of the two stations lasted eight minutes, with one minute for case reading and seven minutes for the practical execution of the station. This time was determined after delineation meetings, in which simulations and tests were conducted with the participation of simulated patients, evaluators, and researchers. To prepare the stations, guiding elements of the literature on the theme were used[30] in addition to the professionalism guidelines proposed by Accreditation Council for Graduate Medical Education[31]. Two meetings were held to standardize and clarify the criteria that would be used by the evaluators, and to discuss the checklist scores.

At all stations, the student should adopt a behavior regarding the data presented. In Station 1, the student approached a simulated patient who had bruises on her left upper limb, face, and abdomen, who reported having suffered aggression from her husband the day before, after refusing to have sex with him. If the student asked, she would provide the following additional information about the patient: she was otherwise healthy; this was not the first time she was assaulted by her husband; she was

a homemaker and a Catholic; she had two children, a boy and a girl, aged seven and ten, respectively; the husband was drunk at the time of the aggression; her husband had previously assaulted her when sober; the date of last menstruation was three months ago (raising the possibility of pregnancy). Station 1 was, therefore, a situation of gender-based violence. In Station 2, the student saw a black transgender patient who works formally as a supermarket teller and informally as a sex worker. She sought care about one hour after being raped during her informal work; reported no use of condoms; did not know the HIV status of her abuser, despite identifying him as a military police officer; and was trembling and had bruises on her face, upper limbs, and knee. Station 2 characterized a situation of violence focused on non-heterosexual sexuality. Both situations took place in the context of a Basic Family Health Unit (BFHU).

The checklists were composed of eight and five items (Stations 1 and 2, respectively) of performance evaluation for each station (situation of violence focused on gender, and situation of violence focused on non-heterosexual sexuality, respectively) and each item was categorized as satisfactory (S), partially satisfactory (PS) and unsatisfactory (U). Table 1 presents the requirements of the checklists and how they were grouped into four categories.

Table 1. Questions to be evaluated in the checklists and categories in each of the two stations.

	Questions	Categorie
	Station 1 (Situation of violence with a gender perspective)	
1	Welcoming the victim, showing empathy and interest in the subjective impressions of what happened.	Empathy (ilness)
2	Inform the patient about the possibility of making a police report.	Legal derivation
3	Report the case for the authorities.	Legal derivation
4	Reinforce the need for periodic visits to the Health Unit, maintaining the link.	Referral for link support and maintenance services
5	Request NASF evaluation (psychology, social work, for example).	Referral for link support and maintenance services
6	Ask for the occurrence of previous aggressions.	Technical conduct of the case
7	Perform radiographs to assess possible fractures.	Technical conduct of the case
8	Take a pregnancy test.	Technical conduct of the case
	Station 2 (Situation of violence with a focus on non-heterosexual sexualities)	
1	Welcoming the victim, showing empathy and interest in the subjective impressions of what happened.	Empathy (ilness)
2	Inform the patient about the possibility of making a police report.	Legal derivation
3	Report the case for the authorities.	Legal derivation
4	Reinforce the need for periodic visits to the Health Unit, maintaining the link.	Referral for link support and maintenance services
5	Inform the patient about the possibility of prophylaxis against DSTs, including HIV (PEP)	Technical conduct of the case

NASF - Family Health Care Center; STDs - Sexually Transmitted Diseases; PEP - Pre-Exposure Prophylaxis.
Source: The Authors

The performance of participants in the four categories was rated as good (above seventy five percent of S on the mean of the two stations), fair (intermediate values), and poor (below fifty percent).

Immediately after completion of the OSCE, 30 minutes were set aside for the i evaluators to provide the participant with face-to-face feedback, and they receive feedback on their performance, as well as were also able to ask the actors for specific feedback on their performance during this allotted time.

This study was previously approved by the Human Research Ethics Committee of Faculdade de Medicina de São José do Rio Preto - FAMERP, under opinion number 3.232.009/2019.

Results and discussion

Of the all the enrolled ckerkships, only little more than a tenth showed interest in participating in the OSCE through the electronic form, attended it (there were no dropouts), and started to integrate the group of participants of the study, undergoing the OSCE. A little more than half of women, a third up to twenty-five years old, and a little more than two thirds of sixth-year clerkships were the characteristics of the group of participants.

The extremely low rate of adherence to the present study presupposes, in addition to a lack of interest in the topic, a non-formal approach to these issues during school, which contributes to the lower (or the complete lack of) interest among students, who are elevated to the point they are not interested in a bonus self-assessment in a controlled environment regarding their skills and competence for such situations.

The predominance of female participants and over 25 years of age corroborate a remarkable tendency toward the feminization of medicine since school[32]. Although there has been an increased mean age by the end of the medical training, probably due to the increased mean age at enrollment, and/or delays in the training process due to failure in subjects or needing to withdraw for a certain period, this is now the mean age group of most students, placing them with millennials who will soon be the predominant workforce and who currently represent almost all resident physicians[33].

In the first station, eight care aspects (items) were evaluated and the students achieved S, first, followed by PS and to a lesser extent U in the aspects. The combined PS and U results are higher than the S results. These results are shown in Figure 1.

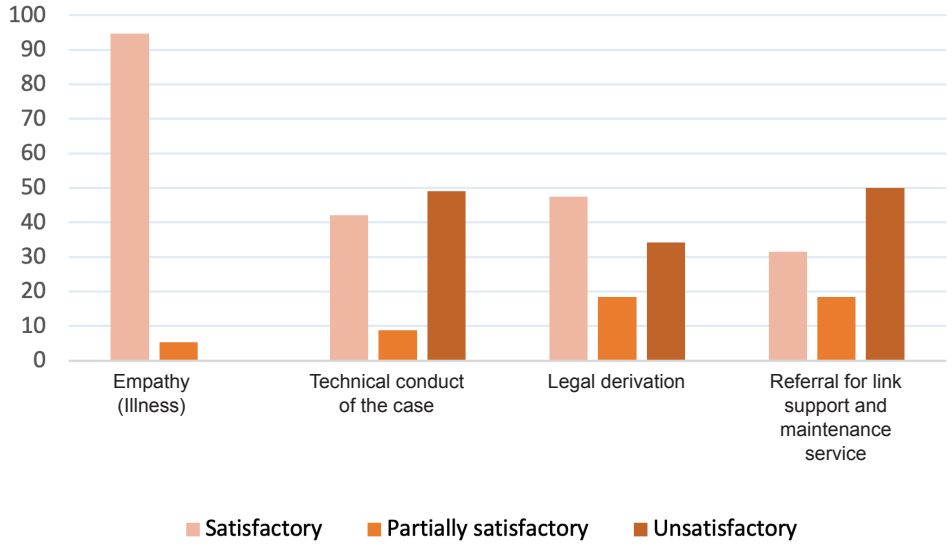

Figure 1. Assessment of competence in dealing with situations of violence focused on gender. (Faculdade de Medicina de São José do Rio Preto - FAMERP, 2020)

Source: The Authors

In the second station, five items were evaluated, and students received S, first, followed by PS and to a lesser extent U in the care aspects. The number receiving an S is greater than the totals of students receiving PS + U, but it was still lower than two thirds, as shown in Figure 2.

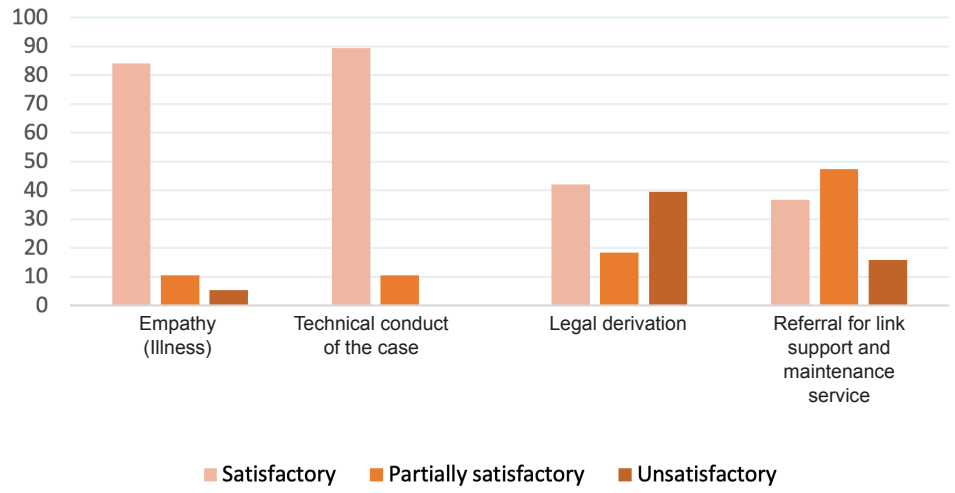

Figure 2. Assessment of competence in caring for situations of violence focused on non-heterosexual sexuality. (Faculdade de Medicina de São José do Rio Preto - FAMERP, 2020)

Source: The Authors

The overall performance of the sample for each category, determined by the mean of each item in both stations, was good for empathy (regarding the illness), regular for technical management of the case, and poor for legal referral and referral for support services and bond maintenance, as shown in Figure 3.

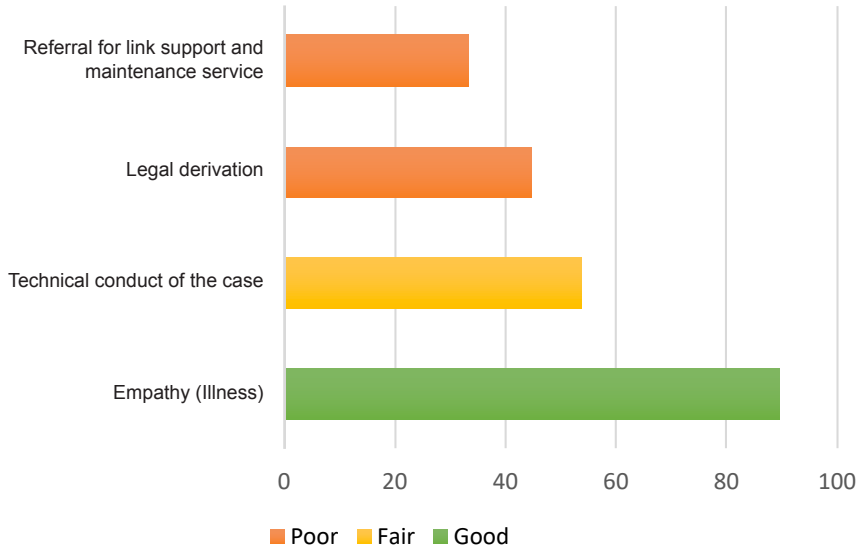

Figure 3. Overall performance of the sample by skill. (Faculdade de Medicina de São José do Rio Preto - FAMERP, 2020)

Source: The Authors

The OSCE was chosen because its practice is a way to assess skills in all its domains, and because it is increasingly used in Brazil and worldwide, although its reliability rate depends on the adequacy of resources, such as the number of stations, station construction, scoring methods, and time allotted[34].

Even considering that many physicians avoid discussing sexuality issues with their patients because they are afraid of invading their privacy, or because these issues are rarely part of a physician's daily clinical practice[35], most patients do not consider their doctor to be invading their privacy if they bring up the subject of sexuality, even if the patient is consulting for a different reason, as long as an appropriate framework of trust, care, and empathy is in place[36]. These data become even more relevant for healthcare in situations of violence focused on gender and non-heteronormative sexualities.

Even the good results in the empathy category (regarding the illness) is still not ideal, showing that there is a long way to have a suitable preparation for a satisfactory welcoming by health professionals in the situations discussed here, which goes against the SUS's principle of equality. Emotional damage undermines trust in the doctor - patient relationship, driving them away from the service. The inability to manage issues specific to violence focused on gender and non-heteronormative sexualities, added to the hegemonic paternalistic medical model - which does not share the therapeutic project and prioritizes its scientific knowledge to the detriment of health needs - are examples of actions that lead to the embarrassment and insecurity of these victims when seeking health services. Unfortunately, there is also the centrality of judgment and attempts to control people's sexuality based on the stereotype of the notion of "deviance", which has a negative impact on the professiona-user relationship and, consequently, presents itself as an important technological barrier for healthcare[37,38].

It is extremely important that the physician is trained to work to reduce emotional damage, not just physical damage[39]. Future training for physicians should focus on

demonstrating the relevance of sexual health in the repertoire of medical knowledge, and on how to deal with their feelings of shame or negative patient reactions during doctor-patient conversations about sexual health and the like[35]. It is also important to consider that the good result in the empathy category (regarding the illness) can also be explained by prior proximity bias, with the participants having encountered the theme previously[40]. It can also be explained by the concept of "preaching to the converted", since such empathy is positively associated with being female, having prior education on the subject, and having minority individuals as peers, as well as by increased levels of competency among participants[40,41].

Results collected at the same institution reveal an evolution in sexual health education over the four years of education that preceded the internship, but the students reported not feeling confident or prepared to address sexuality while developing the doctor-patient relationship[11].

The regular result for the technical management of the case shown here is repeated in the few studies on the subject, since the technical dimension of care involves welcoming the patients, the integrality of care, creating a bond, being committed, and quality of care, and this dimension was pointed out in all studies as having the greatest impact on access to and satisfaction with health services[39].

The poor result for legal referrals and referral for support services and bond maintenance can be understood as the result of the inefficiency of formal education in medical ethics and forensic medicine throughout their training, leading to poor performance in the principles of patient autonomy and beneficence/non-maleficence, as demonstrated by Barchi *et al*[42], leading to questions such as: 1) Have CS been taught and evaluated during the process of training students and professionals in the health area in Brazil?; 2) What instruments have been used?; and 3) What advances in the evaluation process of this competence are still needed in the country?[10] It is important to emphasize that the establishment of a bond is essential to create an environment in which it is possible to provide the necessary guidelines, which go beyond the issue of the moment. One must be a facilitator to work with several issues, such as those related to treatment and medication adherence, meeting the SUS principles and the expanded concept of health, and offering healthcare aimed at preventing complications and promoting health, as recommended by the Primary Healthcare Policy[11,43].

The greatest contribution is to highlight the poor performance in legal and support aspects for the situations addressed, violating the concept of comprehensive healthcare and the need to promote human rights among medical professionals from school to professional practice, so that there is equitable access, free from prejudice and discrimination, and care based on empathy and compassion. The fact that the study did not consider the assessment of aspects that may interfere with the correct acquisition of reasoning and critical judgment in situations of violence focused on gender and non-heteronormative sexualities in clinical contexts, such as the level of integration in previous subjects studied, specific difficulties that a student may present for reflection and analysis and, finally, the effect of the unknown on these skills, as this was not the scope of the present study may be limitations.

Medical schools must incorporate the teaching of professionalism into the curriculum to ensure that the next generations of physicians are prepared for a compassionate, humanistic, and ethical professional practice, permeable to the interest of society in a world of ever-increasing and ever-changing demands.

Creating an overview of the themes being taught in training programs, including the formal curriculum and the parallel curriculum, while specifying their content and approaches, would be extremely relevant to this discussion.

The data speak in favor of an institutionalized training policy as the first step toward getting the healthcare sector to prioritize competence in healthcare for victims of violence focused on issues related to gender and non-heterosexual sexuality.

Assessing the effect of this training on the response of medical students and physicians to situations of violence focused on gender and non-heterosexual sexualities is a challenge that must be faced now and in the coming years.

Conclusion

Low adherence presupposes that these themes are not formally addressed during undergraduate courses, contributing to the lower (or complete lack of) interest of students, since the bias of prior proximity to the topic among the participants must also be considered. OSCE results show regular-to-good performance for illness and technical management of the case, but poor for legal and support aspects in the situations addressed, violating the concept of comprehensive healthcare for victims of violence focused on gender and non-heterosexual sexuality issues.

Authors

Alba Regina de Abreu Lima[d]
<alba.lima09@gmail.com>
Júlio César André[e]
<julio.andre@famerp.br>

Affiliation

[d, e] Centro de Estudos e Desenvolvimento de Ensino em Saúde, Faculdade de Medicina de São José do Rio Preto. Avenida Brigadeiro Faria Lima, 5416, Vila São Pedro. São José do Rio Preto, SP, Brasil. 15090-000.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Financing

The main author was a fellow of the CNPq Institutional Scientific Initiation Scholarship Program – PIBIC CNPq

Conflict of interest

The authors have no conflict of interest to declare.

Editor
Ana Flávia Pires Lucas d'Oliveira
Associated editor
Elaine Reis Brandão

Submitted on
03/27/22
Approved on
10/14/22

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Resumo

As escolas médicas devem incorporar o ensino do profissionalismo ao currículo para garantir que as próximas gerações de médicos estejam preparadas para uma prática profissional compassiva, humana e ética, adequada aos interesses da sociedade em um mundo com demandas cada vez maiores e em constante mudança. A maior contribuição deste estudo é evidenciar o fraco desempenho dos estagiários nos aspectos jurídicos e de apoio nas situações abordadas. Os dados falam a favor de uma política de capacitação institucionalizada como o primeiro passo para que o setor da saúde priorize a competência em atenção à saúde das vítimas de violência relacionada a gênero e a sexualidade não heterossexual.

Palavras-chave: Educação médica. Atenção à saúde. Sexualidade. Identidade de gênero. Competência clínica.

Resumen

Las escuelas médicas deben incorporar la enseñanza del profesionalismo al currículo para asegurar que las próximas generaciones de médicos estén preparadas para una práctica profesional compasiva, humana y ética, adecuada a los intereses de la sociedad en un mundo con demandas cada vez mayores y en constante cambio. La mayor contribución de este estudio es mostrar el deficiente desempeño de los pasantes en los aspectos jurídicos y de soporte de las situaciones abordadas. Los datos se muestran a favor de una política de capacitación institucionalizada como un primer paso para que el sector de salud priorice la competencia en atención a la salud de las víctimas de violencia relacionada al genero y a la sexualidad no heterosexual.

Palabras clave: Educación médica. Atención a la salud. Sexualidad. Identidad de género. Competencia clínica.