



ISSN: 2230-9926

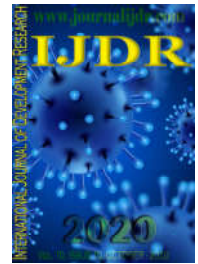
Available online at <http://www.journalijdr.com>

IJDR

International Journal of Development Research

Vol. 10, Issue, 10, pp. 41529-41541, October, 2020

<https://doi.org/10.37118/ijdr.20310.10.2020>



RESEARCH ARTICLE

OPEN ACCESS

BIOETHICAL PRECEPTS AND COMMUNICATION SKILLS ASSESSED BY THE OSCE IN CLERKSHIP STUDENTS

¹Paulo Renato Barchi, ²Beatriz Angélica Cruz, ³Eudes Quintino de Oliveira Júnior, ⁴Emerson Roberto dos Santos, ⁵Alba Regina de Abreu Lima, ⁶Sérgio Luís Aparecido Brienze, ⁷Patrícia da Silva Fucuta, ⁸Helena Landim Gonçalves Cristóvão and ⁹*Júlio César André

^{1,2}Undergraduate Student in Medicine - Medical School of Medicine of São José do Rio Preto - FAMERP, Brazil

^{3,7}Posgraduation Program in Psychology, Medical School of Medicine of São José do Rio Preto - FAMERP, SP, Brazil

⁴Posgraduation Program in Nursing, Medical School of Medicine of São José do Rio Preto - FAMERP, SP, Brazil

^{5,6,9}Center for the Study and Development of Health Education - CEDES, Medical School of Medicine of São José do Rio Preto - FAMERP, Brazil

⁸Department of Pediatrics, University of Santo Amaro (Unisa), São Paulo (SP), Brazil

ARTICLE INFO

Article History:

Received 17th July, 2020

Received in revised form

19th August, 2020

Accepted 20th September, 2020

Published online 30th October, 2020

Key Words:

Medical Education,
Bioethics,
Attitude of Health Personnel,
Professional Competence,
Communication skills.

*Corresponding author: Júlio César André

ABSTRACT

Aims: Qualitatively assessment communication skills and medical ethical knowledge acquired during graduation, through the Objective Structured Clinical Examination (OSCE), of clerkship students of the Medical School of São José do Rio Preto - SP/BR. **Methods:** Research with cross-sectional observational design, qualitative and quantitative methodologies, consisting of taking an OSCE and preceded by a questionnaire, applied to clerkship students, dealing with the content of the Code of Medical Student Ethics (CMSE). **Results:** 29 academics answered the questionnaire and of these 19 took the OSCE. The knowledge assessment about CMSE showed a predominance of good and very good evaluation grades, 51.8% and 27.6%, respectively. The categories with the most satisfactory performances were empathic communication and accessible communication (71.1% and 66.7%), with satisfactory evaluation grades. In the OSCE, the lowest performances were in the categories of autonomy and beneficence, both with 31.6% of satisfactory, while assertive communication and non-maleficence had an intermediate performance (54% and 47.4%), of satisfactory. **Conclusions:** The study showed that the knowledge of FAMERP medical clerkship students about CMSE, although relatively adequate in general terms, lacks improvement and association of this knowledge with practical scenarios and academic routines and the results presented herein denote the course's contribution, as it is currently structured, for the development of communication skills and for the applicability of medical ethical knowledge and, therefore, the regular to good performance for communication skills, the same is tolerable for the principles of patient autonomy and beneficence/non-maleficence.

Copyright © 2020, Paulo Renato Barchi et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Citation: Paulo Renato Barchi, Beatriz Angélica Cruz, Eudes Quintino de Oliveira Júnior, Emerson Roberto dos Santos, Alba Regina de Abreu Lima, Sérgio Luís Aparecido Brienze, Patrícia da Silva Fucuta, Helena Landim Gonçalves Cristóvão and Júlio César André. 2020. "Bioethical precepts and communication skills assessed by the osce in clerkship students", *International Journal of Development Research*, 10, (10), 41529-41541.

INTRODUCTION

In the contemporary democratic context, the phenomenon of the judicialization of health expresses legitimate demands and modes of action by citizens and institutions, for the guarantee and promotion of citizenship rights widely affirmed in the international and national laws (VENTURA *et al.*, 2010). The phenomenon involves political, social, ethical and health aspects, which go far beyond its legal component and the management of public services.

When analyzing the national and international scientific evidence in the specialized literature in jurisdiction, three main aspects occur: the first one, legal proceedings, which are the cases of requests for drugs and high-cost health services; followed by complaints about medical liability, cases of errors due to negligence, malpractice, misconduct and similar attitudes; and the third one is ethical conflicts, which result in legal measures. (BATISTELLA *et al.*, 2019; CADIDÉ & REGINA, 2019; OLIVEIRA *et al.*, 2020)

Batistella *et al.* (2019) in a recent study in the United States of America, where medical errors are ranked as the third leading cause of death, have analyzed mortality data in the country for eight years. The authors found that the annual number of deaths exceeds 250 thousand, attributed to medical errors. An important fact to be highlighted is the lack of publications on the subject due to the omission of the scientific community, considering that many countries are subordinated to political and structural complications. Legal proceedings take place when harm to the patient's health is caused by a medical error. However, this professional error can be defined as the culpable conduct of the physician, in the exercise of the profession, without the intention of committing it. In recklessness, the error occurs when the doctor shows attitudes without due care or even when he is aware of the risks and, even so, disregards ethics during professional practice, making decisions prematurely. In addition, the most frequent form of medical error is negligence, embodied in the omission of their duties and rights. This happens when the medical professional underestimates the patient and/or despises the institution, causing non-compliance with ethical conduct (COSTA, 2019; NASCIMENTO *et al.*, 2020).

The literature also points out that medical error can be divided into two new categories: inevitable and avoidable. The inevitable goes beyond the competence of the professional, as it occurs in many cases due to the lack of resources, technical conditions or even the deficit of medicine itself. However, avoidable errors are part of the professional's direct control repertoire and are usually their responsibility (BATISTELLA *et al.*, 2019; CADIDÉ & REGINA, 2019; COSTA, 2019; OLIVEIRA *et al.*, 2020). Nascimento *et al.*, (2020) points out that "in the last few years there has been an increase in the number of legal proceedings against doctors" and that, therefore, it is necessary to have a medical contract, with its principles and characteristics. Open paths for the identification of factors linked to the health-disease process, as well as for the identification of recurrent vicissitudes in the provision of health services, for the definition of principles of action and the reformulation of some public policies so that they are more in line with the desires (field of possible social expectations) will place us before the sociology of emergencies (BASTOS & FERREIRA, 2019).

In the last decades, the discussion of ethics in medicine has exceeded the limits of professional practice, extending to undergraduate students. This is justified, at least in part, by the fact that medical training, when inserting the student in different practice scenarios, places the need for the formulation of principles of conduct based on the performance and relationship of the student with his teachers, peers, members of health teams and patients (RACT & MAIA, 2012). Some versions of the Codes of Medical Student Ethics (CMSE) have been published, especially those printed and distributed by the regional councils of medicine of the Federal District (RCM/FD) (RMC/FD, 2004) and São Paulo (Cremesp) (CREMESP, 2007). These documents are explicitly mirrored in the current Codes of Medical Ethics (CME) promulgated by the Federal Council of Medicine (FCM, 2018), in its 2018 version (FCM, 2018). We currently have a version published by the Federal Council of Medicine (FCM, 2018) and a more current version of the Regional Council of Medicine of São Paulo (Cremesp) (CREMESP, 2015). In 2005 (LEMOS *et al.*, 2005), based on the belief that the professional training process would influence his future ethical behavior, and aiming to

promote the discussion of the issue, ACADEMÉTICA (Association of Medical Academics for the Study of Medical Ethics and Bioethics) developed a Proposal of the Code of Medical Student Ethics in Bahia. Lisboa *et al.* (2014) affirm that: "the teaching of medical ethics, bioethics and the humanities in the medical course is extremely important, as in undergraduate courses the student builds the bases of his future doctor-patient relationship". Thus, it is important to establish clear rules, of rights and duties of academics towards their peers, teachers and patients during the years of university education. Therefore, the creation of the Code of Medical Student Ethics was so that it could serve as a pedagogical instrument to stimulate ethical reflection on medical practices. These rules presented at CMSE are not intended to be punitive, but a tool for acting and guiding the student's ethical behavior and professional (MENEZES *et al.*, 2017). It should be noted that the aim is also to favor the well-being of patients and promote the safety of society (LISBOA *et al.*, 2014; MENEZES *et al.*, 2017). Comparing the 2 most current ones, that of FCM and CREMESP, we find the following similarities: both address fundamental principles, student rights, duties and prohibitions, the relationship with the patient, medical secrecy, teaching and medical research issues, the relationship with institutions, as well as with healthcare professionals, colleagues, teachers and advisors. It is noteworthy that CREMESP separates its articles by chapters, while FCM by axes and FCM addresses in the Fundamental Principles articles that CREMESP dedicates to specific chapters (CREMESP, 2015; FCM, 2018). These analyzes also allow us to understand that the CMSE of FCM discusses the student's responsibility with his studies/training, his relationship with society and with the multidisciplinary team. It also presents a remissive index for greater clarity and provides contacts from the Regional Councils of Medicine (RCM) and national entities of interest. These axes are not addressed in the CREMESP text, which, however, brings in its last chapter articles about medical students' clerkship and ends with the Hippocratic oath. This is a way of reinforcing the principles that govern medicine. These last two topics are not found in the FCM text (CREMESP, 2015; FCM, 2018).

With a unified code of ethics, even with versions added to the particularities of some institutions, safe action is possible (LISBOA *et al.*, 2014; CREMESP, 2015; MENEZES *et al.*, 2017; FCM, 2018). An example of the importance of CMSE is the fact that many patients are unaware that they are being attended by students, however they are protected from the possibility of illegal practice of medicine by these students. It is worth mentioning that human learning in medical education represents an active process for everyone, be they professors, pupils and patients, in a social context that does not demand a simple knowledge of rules (LEMOS *et al.*, 2005; RACT & MAIA, 2012 ; LISBOA *et al.*, 2014; MENEZES *et al.*, 2017). In this context, questions emerge, such as: since the MCE applies to the standardization of the conduct of medical professionals, how does the code of medical student ethics incorporate ethical issues into the training process? The study of the topic goes beyond the simple analysis of a set of documents, and may even trigger discussions of the councils with students, with a view to elaborating future versions of more current codes, in line with the profile that society demands from the doctor (RACT & MAIA, 2012). Although professionalism is recognized as an important quality by professional bodies and higher education providers (HAMMER, 2000; THURSTON *et al.*, 2018), its definition

may not be clear enough for professionals (HAMMER, 2000), which does not facilitate accurate measurements (HAMMER, 2003; MYLREA *et al.*, 2015). The term professionalism has been used in different ways. Professionalism has been defined as exhibiting beliefs, principles and attitudes that serve the best interests of patients above the personal interests of professionals (BEARDSLEY, 1996). Professionalism, in general, can be defined as being useful to the community, acquiring autonomy to allow the individual to make professional judgments without external help from third parties, having a sense of responsibility and fulfilling their duty regardless of external rewards. Professionalism can also be described as a behavior or valuable aims that distinguish a profession (HAMMER, 2003).

Professionalism must be considered in all health professions. In medicine, the American Board of Internal Medicine (ABIM) outlined three commitments to professionalism for doctors: a commitment to sustain the interest and well-being of the patients; accountability to quality excellence; and a commitment to be responsive to the community's health needs. These were followed by 6 additional domains of professionalism expected from doctors: (1) excellence in performance to meet or exceed ordinary expectations and the pursuit of lifelong learning and individual development; (2) altruism in the concern for and prioritization of patients' well-being above self-interest; (3) responsibility to be responsible for responding to patients, as well as for society and the health profession; (4) honor and integrity, being fair and honest and reflecting credibility in performance; (5) duty of care, including a commitment to ensure the safety and health of the patient through the provision of high-quality care; and (6) respect for others, including patients, their families, peers at work and other healthcare professionals (BLACKALL *et al.*, 2007).

Chalmers' definition of professionalism, which requires consideration and respect for others, empathy, commitment, maintaining boundaries and confidentiality, harmonizes with the ABIM definition (CHALMERS, 1997; HAMMER *et al.*, 2000). Hammer *et al.* (2000) further modified the 6 domains of professionalism proposed by ABIM to suit other students in the healthcare field, such as those in pharmacy for example, particularly noting responsibility, initiative, maturity, appearance, competence, standards and interpersonal communication skills. The evaluations and interpretations discussed have evolved over time (WILKINSON *et al.*, 2009) and, although the definitions discussed above understand the core of professionalism and share many of the elements of professional practice, the real elements are mainly descriptive, relatively comprehensive and inaccurate (DUBBAI *et al.*, 2019). Researchers have conceptualized various models to describe the range of elements necessary to be a professional in healthcare with professionalism, including the umbrella model (HAMMER, 2003) and the bicycle wheel model (ROTH & ZLATIC, 2009). Since professionalism is an active and multi-domain concept, likewise, the bicycle wheel model is dynamic in its regular rotations and spokes. Each spoke means a domain of professionalism, which jointly acts to reinforce the wheel. In this model, principles such as honesty and a sense of responsibility occupy the center of the wheel and depict the importance of incorporating such principles in the practice of healthcare professionals, for example, communication while counseling patient (ROTH & ZLATIC, 2009). Being a doctor requires specialized

knowledge and skills that require continuous maintenance and good communication skills. Doctors - regardless of specialty - must be able to discern the concerns, goals and preferences related to patients' health care and work in multidisciplinary teams (for example, teams made up of other doctors, nurses, physiotherapists, pharmacists, social workers, students, etc.), all of these tasks require good communication skills. Being a doctor also requires a solid knowledge of ethics. Due to the nature of their work, doctors inevitably encounter ethical dilemmas (for example, requests to withdraw treatments that prolong the lives of patients who are unable to make decisions, medical futility, duty of care during epidemics, etc.). (MUELLER, 2015). There is a number of reasons why professionalism among medical students and practicing doctors is important, namely: patients expect doctors to be professionals, medical societies and accreditation organizations expect doctors to be professionals, professionalism it is associated with better medical results and there is a business case for professionalism (MUELLER, 2015). Maintaining and enhancing professional behavior requires measurements. A valid measurement is essential to assess any behavior (HRISOS *et al.*, 2009). Berenson (2016) emphasized the importance of measurement processes, stating that, "if you cannot measure, you cannot manage it", which means that unmeasured parameters cannot be improved (BROADBENT, 2005).

There are various principles that should regulate the assessment of professionalism, whether in medical students or doctors in activity and include: the duty to use various assessment tools (knowledge tests, that is, "cognitive basis", multi-source 360-degree reviews, for example, by college members, colleagues, associated healthcare staff [for example, nurses] and others, objective structured clinical examinations (OSCE), patient assessments, simulation, critical incident reports, assessments of patient complaints and lapses in professionalism); individuals must know that they are being assessed for professionalism, assessment should begin at the beginning and continue throughout the careers of individuals; all levels of the medical hierarchy must be assessed; assessments must be relevant to the individual's level of education and specialty setting; the data collected should be used for formative and summative feedback and "portfolios" of professionalism (MUELLER, 2015). The Objective Structured Clinical Examination - OSCE was developed according to the need and difficulty of analyzing some competencies and was designed for medical education and standardized for greater reliability (SANDOVAL *et al.*, 2010; MARWAHA, 2011; BOGO *et al.*, 2012).

It was at the University of Dundee, UK, in 1975 that one of the first OSCE implementation initiatives took place. From that moment on, it became an important tool to assess clinical skills, knowledge, attitudes, communication and professionalism. Since then, it has been applied in the evaluation of medical students and residents, in summative or formative evaluations worldwide (AMARAL & TRONCON, 2007; BAIG *et al.*, 2009; GUPTA *et al.*, 2010; DUVIVIER *et al.*, 2012). Therefore, the OSCE is among the gold standard exams to objectively assess medical skills (GUPTA *et al.*, 2010; MARWAHA, 2011), since it is not restricted to knowledge, but includes the ability to exercise it (BUSTAMANTE *et al.*, 2000). Among the essential competences in clinical practice, we have clinical communication and professionalism, for which the OSCE has

been a method used with some frequency and with good results in some studies (ABADEL & HATTAB, 2004; SCHIRMER *et al.*, 2005; PREARO *et al.*, 2012; SÁNCHEZ *et al.*, 2013). Among its applications, it has the ability to assess anamnesis, physical examination and interpretation of clinical results, with emphasis on effective communication (SANDOVAL *et al.*, 2010; BOGO *et al.*, 2012). In addition, it allows evaluating attitudes and behaviors in situations involving ethical dilemmas (FRANCO *et al.*, 2015). The sense of social responsibility and commitment to citizenship of the graduates includes cultivating, reinforcing and offering situations that promote ethical sense and justice during the training phase. Ethical dilemmas abound in the medical profession, hosting debates and discussions inside and outside the classroom. Studies corroborate little evolution of academic knowledge about medical bioethics during graduation, pointing to a future of increasing number of ethical failures in the medical field if changes in the learning of these issues are not instituted (GODOY *et al.*, 2014).

Quantitatively assessment the knowledge of medical students about the Code of Medical Student Ethics (CMSE) and qualitatively the communication skills and medical ethical knowledge acquired, based on the principles of autonomy and beneficence (BEAUCHAMP & CHILDRESS, 2002), during education, through Objective Structured Clinical Examination - OSCE, of the clerkship students of the Medical School of São José do Rio Preto - SP (FAMERP), was the objective of this work. Since medical schools are undergoing substantial changes in their teaching-learning process, added to the growing medical judicialization, it was pertinent to carry out this work in order to assess the contribution of the FAMERP medical course, as it is currently structured, for the development of the professionalism of its almost professionals (clerkship students).

MATERIALS AND METHODS

Type of Study: This study is characterized by a cross-sectional observational design, using both qualitative and quantitative methodologies. The study consists of the taking an OSCE and preceded by the application of an evaluative questionnaire to academics dealing with the content of CMSE.

Study participants: The study individuals were the 5th and 6th graders of the medical course (clerkship students) at the Medical School of São José do Rio Preto - SP (FAMERP) in 2020, which received a link with invitation, Free and Informed Consent Form (FICF) and electronic form with the questionnaire and a final item to express your participation in the OSCE. The present study was previously approved by the Ethics Committee on Research in Human Beings of the Medical School of São José do Rio Preto (FAMERP) according to the opinion number 3.232.009/2019.

Description of the evaluative questionnaire: Built by the researchers and dealing with the CMSE content, it consisted of 10 questions with an assertive statement and alternatives that are true, false and unknown. They were distributed in the following themes: basic knowledge of CMSE (1 question); knowledge of the medical student's rights (2 questions); knowledge of the medical student's duties (4 questions); knowledge of what is forbidden to the medical student (2 questions); knowledge of medical confidentiality (1 question). For each question that the academic chose the correct

alternative between true and false, 1 point was assigned and for each question that the academic chose the wrong alternative between true and false or opted for the alternative, 1 do not know no point was assigned. The final score was assigned by the sum of the points and the results described in ranges: 0 - 2 points (very bad); 3 - 4 points (bad); 5 - 6 points (regular); 7 - 8 points (good); 9 - 10 points (very good).

Description of the OSCE implementation steps

Setting the number of stations: The number of stations has considered the number of evaluators and actors available for the process. There were two evaluators and two simulated patients, all of whom had experience in theater or arts. The evaluators were volunteers, not teachers of the institution, healthcare workers with experience and/or training in teaching in the healthcare area. Both the simulated patients and the evaluators were participating in their first OSCE. There were two stations that assessed communication skills and recognition of bioethical principles, elements of professionalism.

Duration of stations: Each station lasted a total of eight minutes, one minute for reading the case and seven minutes for the practical execution of the station. This time was determined after the beacon meetings, in which simulations and tests were carried out with the participation of simulated patients, evaluators and researchers.

Content of station: To elaborate the stations, reference elements from the literature on the theme were used (HOPPE *et al.*, 2013; FRANK *et al.*, 2015) and the guidelines proposed by the Accreditation Council for Graduate Medical Education (2016) for professionalism. In all stations, the student should adopt a conduct in view of the data presented. There were simulated patients in both stations. In station 1, the academic approached the (simulated) husband of a patient who had a single kidney, with indication for hemodialysis and who is religiously part of Jehovah's Witnesses, the husband refuses permission for hemodialysis and threatens to sue the doctor if he does it without your consent. In station 2, the academic attends a simulated, heterosexual, married patient, to report the positive result of serology for the human immunodeficiency virus (HIV) and who refuses to share the result with his wife. Two meetings were held to standardize and clarify the criteria to be used by the evaluators as well as to discuss the checklist scores.

Checklist: The checklists consisted of 6 performance evaluation items for each station and each item was categorized as satisfactory (S), and the academic received 1 point, partially satisfactory (PS) and half point and unsatisfactory (I) where no point was assigned. The final score for each station was the sum of all items on the checklist for each station. Table 1 presents the requirements for the constitution of the checklists and how they were grouped into categories. Table 1. Items to be assessed in the checklists, and categories, in each of the two stations.

RESULTS

Of the 160 clerkship students registered (total population), only 29 joined the study sample (18.1% = adherence rate) and of these only 19 (11.9%) submitted to the OSCE.

Table 1. Items to be assessed in the checklists, and categories, in each of the two stations

Items	Categories
STATION 1	
Introduce himself/herself, greet the husband and invite him to sit in the office chair	EMPATHIC COMMUNICATION
Explain the clinical case to the husband, using appropriate language	ACCESSIBLE COMMUNICATION
Explain the hemodialysis procedure and how it works	ACCESSIBLE COMMUNICATION
Discuss alternative therapies such as peritoneal dialysis	AUTONOMY
Faced with husband's refusal, opt for dialysis, even against the family option	BENEFICIENCY
Defend his/her conduct safely	ASSERTIVE COMMUNICATION
STATION 2	
Calm the patient, explaining that it is possible to have an almost normal life	EMPATHIC COMMUNICATION
Explain to the patient that he should talk to his wife as this directly influences her life	ASSERTIVE COMMUNICATION
Explain the treatment and ask for CD4 count and viral load	ACCESSIBLE COMMUNICATION
Notify the case	ASSERTIVE COMMUNICATION
Forward to reference service	ASSERTIVE COMMUNICATION
In view of the patient's refusal to tell the case to his wife, he/she warns him that he will do it	NO MALEFICENCE

Table 2. Performance of students in the evaluative questionnaire about the Code of Medical Student Ethics, by total answers. (FAMERP, 2020)

Item	Correct answers n (%)	Wrong answers n (%)	Unknown n (%)	Number of answers of items
Basic knowledge of CMSE	25 (86.2)	2 (6.9)	2 (6.2)	29
Knowledge of the medical student's rights	35 (60.3)	10 (17.2)	13 (22.5)	58
Knowledge of the medical student's duties	77 (66.4)	28 (24.1)	11 (9.5)	116
Knowledge of what is forbidden to the medical student	48 (88.8)	3 (5.2)	7 (12.0)	58
Knowledge of medical confidentiality	24 (82.8)	1 (3.4)	4 (13.8)	29

Table 3. Overall performance in the evaluative questionnaire about the Code of Medical Student Ethics (n = 29, FAMERP, 2020)

	Number of assessment items	Average correct answers	Standard deviation	Median of correct answers
Evaluative questionnaire about the Code of Medical Student Ethics	10	7.21	2.02	7.0

Table 4. Performance of academics in the OSCE by categories, in both stations, by number of responses (FAMERP, 2020)

Categories	Unsatisfactory n (%)	Partially satisfactory n (%)	Satisfactory n (%)	Total n (%)
ACCESSIBLE COMMUNICATION	5 (8.7)	14 (24.6)	38 (66.7)	57
EMPATHIC COMMUNICATION	1 (2.6)	10 (26.3)	27 (71.1)	38
ASSERTIVE COMMUNICATION	26 (34.2)	9 (11.8)	41 (54.0)	76
AUTONOMY	11 (57.9)	2 (10.5)	6 (31.6)	19
BENEFICIENCY	8 (42.1)	5 (26.3)	6 (31.6)	19
NO MALEFICENCE	4 (21.1)	6 (31.6)	9 (47.4)	19

OSCE, Objective Structured Clinical Examination

Table 4. Achievement and performance in the OSCE, AUTONOMY category, according to the performance on the same theme in the evaluative questionnaire about the CMSE content (n = 29, FAMERP, 2020)

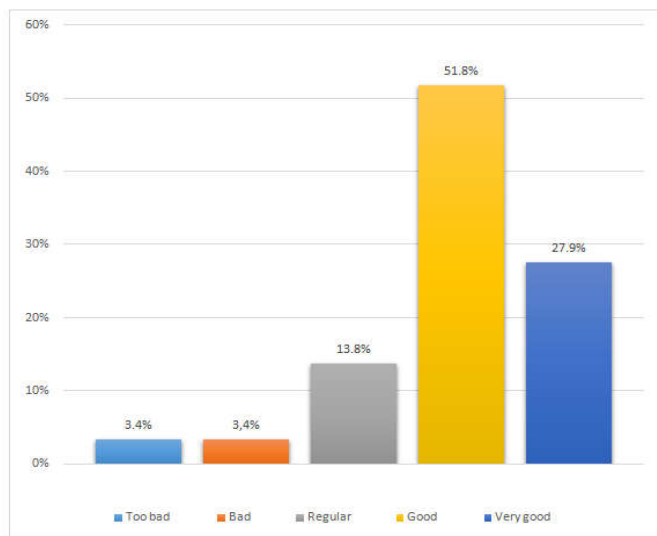
Achievement and performance in the OSCE: AUTONOMY category					
	Did not take the OSCE n (%)	Unsatisfactory n (%)	Partially satisfactory n (%)	Satisfactory n (%)	Total n (%)
Question 9 of the evaluative questionnaire: AUTONOMY category					
Correct answer	6 (25.0)	10 (41.7)	2 (8.3)	6 (25.0)	24 (100)
Wrong answer	2 (100)	0 (0)	0 (0)	0 (0)	2 (100)
Unknown	2 (66.7)	1 (33.3)	0 (0)	0 (0)	3 (100)
Total	10 (34.5)	11 (37.9)	2 (6.9)	6 (6.9)	29 (100)

OSCE, Objective Structured Clinical Examination

As for gender, the sample consisted of 16 (55.2%) females and 13 (44.8%) males; for the age range, 9 (31%) were below 25 years old and 20 (69%) above; and as for the grade, 9 (31%) were of the 5th grade and 20 (69%) were of the 6th grade. The performance of the evaluative questionnaire about the CMSE content can be seen in Table 2. The overall performance in the CMSE content questionnaire can be seen in Table 3. Considering the final score attributed by the sum of the points of each academic and the results described in the correct

answers ranges and their respective evaluation grade, we have the results shown in Graph 1. The performance of academics who performed the two OSCE stations, evaluating their attitudes in the 12 questions (6 questions each station) grouped in the categories accessible, assertive and empathic communication and the principles of autonomy and beneficence/non-maleficence are shown in Table 4. The categories with the most satisfactory performances were empathic communication and accessible communication, with

71.1% and 66.7%, respectively, of satisfactory evaluation grades.



Graph 1. Distribution of academics according to the EVALUATION GRADE obtained, according to the correct answers range in the evaluative questionnaire about the Code of Medical Student Ethics. (n = 29, FAMERP, 2020)

The lowest performances were observed in the categories: autonomy and beneficence, both with 31.6% of satisfactory evaluation grades, while the categories of assertive communication and non-maleficence presented an intermediate performance, with 54% and 47.4%, respectively, of satisfactory evaluation grades. The comparative analysis of the performance in the evaluative questionnaire about the CMSE content with the variables gender ($p = 0.606$), age group ($p = 0.111$) and grade ($p = 0.530$) did not show statistically significant differences. Considering the existence of a question in the evaluative questionnaire about the CMSE content that addressed the topic of autonomy, which was also an OSCE category, we compared the correctness of that question with the performance in the OSCE in the same category and the results can be seen in the Table 5.

It was observed that, of the 24 students who answered the theoretical question correctly, 6 (25%) did not take the OSCE, 10 (41.7%) presented unsatisfactory performance, 2 (8.3%) partially satisfactory and 6 (25%) presented satisfactory performance. Of the 2 who presented unsatisfactory performance, both did not take the OSCE.

Of the 3 who did not know the answer, 2 (66.7%) did not take the OSCE and 1 (33.3%) presented an unsatisfactory performance.

DISCUSSION

The world has changed, Medicine has evolved, new scenarios of professional practice have emerged and, as a consequence, Medical Ethics has been updated in line with the demands of the times that pose questions that did not exist until then. Medical ethics, by contingency, is unveiled in situations that were previously established, but changed in form and content, such as the relationship with the drug, prosthesis, orthosis and special materials industries. In the latter, technological incorporation in medicine was accompanied by both important benefits and risks of the commodification of medical practice.

Herein, it is worth remembering Milton, a 17th century English poet about the layman's discussion of reading the Bible - "There is no benefit that does not bring the possibility of some harm to its core" (CREMESP, 2015). Medical errors almost always cause harm and suffering to patients, which, together with an unsatisfactory doctor-patient relationship, is responsible for most of the complaints made in the Regional Councils of Medicine (RCM). Inaccuracies committed by professionals in other areas may not have any major consequences, but medical errors often cause unwanted results and, often, irreversible sequelae (D'ACAMPORA & CORRÊA, 1996).

Various factors are involved in the increase in the number of medical errors cases, such as greater public awareness of their rights, precarious working conditions, especially in the public sector, and the influence of the media. Among the most important factors in generating this situation are the deterioration in the quality of the doctor-patient relationship and the deficient training of doctors during undergraduate and graduate courses (KFOURI NETO, 1999). The recognition of the role of medical education in the prevention of medical error must be discussed urgently, mainly due to the growing number of medical schools in the country. According to a report by the Interinstitutional Commission for the Evaluation of Medical Education (ICEME), Brazilian medical schools, in general, are not training professionals to meet the demands of the population. The recently graduated professionals leave colleges with a deficient ethical and humanistic training, a functionalist conception of the health-disease process, early specialization and unable to keep up to date (PICCINI *et al.*, 1997; REGO, 2003). The unsatisfactory ethical training of the doctor contributes to the occurrence of deviations in conduct during the exercise of the profession (LESTER & TRITTER, 2001). The lack of knowledge about medical ethics, observed in most doctors, and the frequency of complaints for ethical infractions before the regional councils of medicine are good reasons to stimulate and develop the teaching of the discipline Medical Ethics. Likewise, the advent of bioethics requires offering doctors in training a solid base of ethical knowledge to prepare them for professional practice, from new angles of view, with the incorporation of new medical, ethical, philosophical, religious and legal concepts. The evolution of society towards full citizenship has also required a more improved ethical conduct from the doctor (GRISARD, 2002). The Code of Medical Student Ethics (CMSE), already adopted in some colleges in the country, is of high didactic value for fostering an ethical awareness in the training stage and should always be encouraged (BITENCOURT *et al.*, 2007).

The low rate of adherence to the assessment of knowledge about CMSE of only 18.1% and of these only 19 (11.9%) submitting to the OSCE presupposes that these themes are not formally addressed during graduation, which contributes for the lesser interest of the students, not to say null since it is still necessary to consider the bias of previous proximity with the theme among the participants (WHITEHEAD *et al.*, 2016). The knowledge assessment about CMSE showed a predominance of good and very good evaluation grades (51.8% and 27.6%, respectively) and this seems appropriate, but a lot can be done to improve this since it can, and should,, expect very good ethical conduct, not just good. A great similarity was observed between the knowledge of the fifth and sixth grades, maintaining similar proportions of right, wrong and unknown answers. We infer, at this point, a failure in the initial perception that ethical knowledge could be

acquired by the multidisciplinary of practice, by transferring the professional experience of preceptors or by discussing cases experienced in practice, considering that the traditional methodology adopted by FAMERP, despite having focuses of professional practice in the other grades, has the highest concentration in the fourth medical grade and in the clerkship cycle. We infer that although there was no statistical difference in knowledge between the 5th and 6th grades, even so the existence of errors is negative, since the ideal would be that there would be no errors. Such absence of errors would mean that, when the academic considered knowing the subject and, in this case, submitted to answer whether the question is true or false, he would correctly dominate it, differently from what was observed (Table 5). Such concept is very important, as it is considered that it is better for the pupil to realize that he has no domain over a certain subject than to believe that he has, when, in fact, he does not master it sufficiently. After all, he who is aware that he does not master a subject has the opportunity to seek to know it; however if he considers to dominate him, but he was mistaken, continues to believe in his false knowledge, because he ignores this fact (GODOY *et al.*, 2014).

Various authors have found a fallback or a stagnation in the competence of ethical knowledge among academics during the course of Medicine (HEBERT *et al.*, 1992; LIND, 2000; PATENAUDE *et al.*, 2003; MENDONÇA *et al.*, 2008), corroborating our results in this regard. The curricular content of the institution, therefore, does not seem to be decisive in the teaching-learning process in this area, despite the disciplines Ethics and Bioethics being part of the curriculum of the course. This implies the need for an early and effective introduction of the subject in undergraduate courses, through a methodology that associates content and practice, enabling the student to recognize ethically conflicting situations and use ethical foundations in order to make autonomous decisions in their professional practice and respect for the individual. Thus, the discipline of Medical Ethics and Bioethics is the discipline that is lacking in Brazilian medical education, in a hierarchical way, as a support and factor of professional success for future doctors and response to society and its inclusion in the medical curriculum allows to correctly inform academics, given them an opportunity to gain knowledge and create awareness that this is an indispensable discipline for successful professional practice (GRISARD, 2002) Maintaining a good doctor-patient relationship is the best way to prevent complaints and lawsuits against doctors. When this relationship is marked by respect, affection, transparency and autonomy, it reaches a high degree of mutual understanding and tolerance, not to the point of allowing errors on the part of any party, but of making failures understandable (GOMES & FRANCE, 1998). From the first lessons, the medical student learns by means of an analytical method that to understand a disease well, he must divide the object of his study into as many parts as possible. The knowledge of the parts is taken to exhaustion and in the sequence, he is oriented to make the union of them to reconstruct the whole. It happens that, frequently, the last part of this task cannot be satisfactorily completed. Walking between the etiological, anatomical and syndromic diagnoses, guided primarily by clinical reasoning, is not an easy task. The lack of domain of this knowledge led us to the current situation of catastrophe in the interpersonal relationship present in the daily lives of health professions. Medicine, originally a rich art of inter-subjective relationship, was reduced to a poor job of measuring biochemical variables. You hear without listening,

as professionals are trained to underestimate the manifestations of human subjectivity. Visits to the wards, carried out in many university hospitals, are characterized by a monotonous sequence of reading of an endless list of vital patient data, obtained through sophisticated equipment. Very often, the professor responsible for the activity, ends the discussion by making some reference to the latest multicentric studies, warning that knowing the indisputable truths presented by evidence-based medicine and ignoring these great "trials" means a serious limitation to the correct decision making scientifically based therapies (LIBONI & SIQUEIRA, 2009).

Professional attitudes can be observed in the daily life of students' academic life at any stage of the curriculum and can assist in converting theoretical learning into practical learning. Performance expectations can be defined based on the role assigned to the student in the activities provided in the educational programs. Thus, by way of example, it is expected that students fulfill their commitments made with colleagues, participate effectively in group activities, arrive at the scheduled time of the planned activities, do not cheat during the evaluations, do not forge their presence in activities where they were effectively absent, that is, demonstrate integrity and responsibility with the activities included in the curriculum and treat their classmates and college members with the same degree of consideration, respect and courtesy that would treat their peers and co-workers if they were already trained and inserted in the labor market. This way it is possible to teach and assessment professionalism considering the daily activities of students and respecting their level of professional development (SANTOS, 2018). Students who demonstrate behaviors considered non-professional during graduation are more likely to have disciplinary problems during their professional lives, reinforcing an aphorism of medical education, "professional students, become professional doctors" (PAPADAKIS *et al.*, 2004).

The behavior considered as non-professional is identified as one of the main causes of adverse effects experienced by patients during the provision of care, which makes medical professionalism a determining factor in the quality of health care (O'SULLIVAN & TOOHEY, 2008). Thus, in addition to potentially being able to predict the future quality of professional practice, attitudes and behaviors, which today form the basis of medical professionalism, have important repercussions on the doctor-patient relationship, on the quality of care and on the results of the intervention on the health-disease process (JHA *et al.*, 2007; O'SULLIVAN & TOOHEY, 2008). Regarding the assessment of professionalism in medical students through domains such as altruism, responsibility, care, teamwork, is frequent, and scenarios or simulated patients; online questionnaires or applications can be used (CARNEIRO *et al.*, 2020). Various ways of evaluating medical professionalism in undergraduate students have been described as: online questionnaires about non-professional behavior witnessed to assess moral distress (MONROUXE *et al.*, 2015); questionnaire with questions about the evaluation of professionalism (identification and correction of lapses) carried out by telephone to the heads of medical schools (ZIRING *et al.*, 2015); forms with multiple choice questions about scenarios that demonstrate situations of unprofessional behavior through the Survey Monkey program (HULTMAN & WAGNER, 2015); Concordance of Judgment Learning tool (CJLT) with clinical cases about professional situations that are judged by students (FOUCALT *et al.*,

2015); Dundee Polyprofessional Inventory questionnaire with answers by the Bristol online survey system (SATTAR *et al.*, 2016); Teaching Meetings Structured by Objectives (OSTE) using simulated patients with lapses of professionalism (TUCKER *et al.*, 2016); e-mail surveys with students and teachers about what they understand about professionalism through three words (RANDALL *et al.*, 2016); PROMOBES - Professional Mobile Monitoring of Behaviors (CENDÁN *et al.*, 2017); situational judgment test (SJT) (GOSS *et al.*, 2017); case report of non-professional attitudes witnessed with reflections on them (PARK *et al.*, 2017); MedU Aquifer Platform (DONG *et al.*, 2017); Professional Identity Formation (PIF) assessed by the Professional Identity Essay (PIE) (KALET *et al.*, 2018). The methods listed here have advantages and disadvantages.

We opted for the OSCE since its practice is a way of assessing competences in all its domains and is increasingly used in Brazil and in the world, although we know that the reliability rate of this exam depends on the adequacy of resources, such as number of stations, station construction, scoring methods and time (GUPTA *et al.*, 2010; MARWAHA, 2011). But the literature shows that the assessment of professionalism is done, most of the time, through the assessment of domains that encompass various attitudes understood as professionals. Various assessment strategies are used, with emphasis on questionnaires, patients and simulated clinical cases, feedback and modeling and, unlike our one-off study, there is a clear need for the association of methods for a better longitudinal assessment, adapted at each stage of the student throughout graduation (CARNEIRO *et al.*, 2020). Communication skills are indispensable for healthcare professionals and there are some instruments validated in Brazilian Portuguese that assess communication skills of students or healthcare professionals. These were developed in Germany and the United States, underwent cross-cultural translation and adaptation into Brazilian Portuguese, followed by analysis of validity evidence for Pharmacy students, the Evaluation of the Pharmaceutical Service Process (MESQUITA *et al.*, 2012) and Nursing, the Competency Scale in Interpersonal Communication (PUGGINA & SILVA, 2014), for nurses, the self-assessment of professionalism and interpersonal communication between nurses and the patient (PEREIRA & PUGGINA, 2017), and doctors, the Skills Assessment Form of Communication Gap-Kalamazoo (AMARAL *et al.*, 2016). However Araújo *et al.* (2020) in a scope review are emphatic in the statement that there is a reduced number of validated instruments for assessing communication skills and despite the existence of numerous types of health courses in Brazil, only Nursing, Medicine and Pharmacy were validation targets for tools for this practice.

In addition, limited data on the validity and reliability of the tools were identified. Cömert *et al.* (2016), in their systematic review, also identified methodological gaps in the reporting of psychometric properties of tools used to assess communication skills in objective structured clinical examinations. The practical applicability of an OSCE station is fundamental and the development of simulated environments must be as close to reality as possible (BURGESS *et al.*, 2013), since close to practice, the scenarios are more relevant and meaningful to students (HUMPHRIS, 2002). The challenge is even greater when the stations involve subjective elements, such as communication and feelings (KHAN *et al.*, 2013). Performance evaluation in a simulated environment is widely

used in medical training. Among the available methods, OSCE is the most used at both undergraduate and graduate levels. Because it is standardized and uses multiple examiners, it is considered a fairer assessment and can be formative or summative (ROCHA *et al.*, 2019). The communication skills (CS) expected from doctors and, consequently, from “quasi-doctors” (clerkship students) include the technique for collecting data during the interview, explanations given to the patient, discussion of the care plan, as well as obtaining consent to perform procedures. Despite the increasing appreciation of CS in medical education, there is still no consensus on what an appropriate doctor-patient communication is. CS assessment methods need to cover different aspects, such as empathy, interview organization, voice intonation and non-verbal language (ROCHA *et al.*, 2019).

Talking about the vitality of language and communication in the most diverse activities of man affirms the maxim that communicating is imperative. Only in language and through language are we constituted as social individuals. The understanding of language and communication are considered transversal knowledge and the main axis of teaching practices in any and all areas of knowledge, including healthcare areas (OLIVEIRA *et al.*, 2017). For the present work, we chose elements of empathic, accessible and assertive communication. Empathic communication presupposes the preparation of students for medical practice in order to observe the person who arrives for care from the complexity and uniqueness of the life story that goes through it. Therefore, there is an emphasis on the narrative that the person elaborates about himself and his condition, extrapolating what could be reduced to the binomial health - disease. It is in this context that empathic communication in medical education becomes an important tool to access the subjectivity of the sick individual, family members and the entire care network cultivated around the patient, even discussing the term empathy and its different understandings, since the biomedical model, which prioritizes the disease to the detriment of the patient, is still effective in medical practice (GUERRA & NEPOMUCENO, 2020).

Within the humanistic and professional context, empathy is important in the doctor-patient relationship. Thus, the patient better exposes his complaints and concerns, providing a better diagnosis and treatment. However, the current doctor is afraid that, being empathic, he may lose his discernment and judgment ability, in addition to suffering with patients, distancing himself from them. This challenge can be overcome by recognizing and reflecting on one's emotions, which fosters constructive and elevated feelings that will result in professionalism, ethical and humanized behavior (MORETO *et al.*, 2018). The role of professors and medical preceptors in stimulating the development of empathy in medical students is notorious, whose role developed in training and behavior directly interfere in the conduct of future doctors. Therefore, important actions in medical courses should be implemented with a view to developing more and more empathy in their teachers and medical preceptors, whose practice will have direct implications for medical students (NUNES *et al.*, 2020). Accessible communication must be the basic principle for the development of all procedures, from clinical to therapeutic. In Brazil, in our times, this vision is not realized, whereas the distance from the linguistic world between the doctor and the patient is perpetuated in the most diverse levels of care and, therefore, there is, on the part of the patient, an adequate

understanding of their problems, treatments proposed by the doctor and, on the part of doctors, there is not a good quality in the promotion, prevention and health care. Thus, it is important to value communicative proximity, even with the different language variants, between doctors and patients, since the patient's understanding, through accessible communication, must be valued at the expense of the mere jargon used by the medical society. Therefore, there is a need to reorganize medical education based on the National Curriculum Guidelines (NCG) of the medical course (BRAZIL, 2014), which advocates the communicative importance during general medical activities so that, it will become possible to develop a medicine based on the valorization of the patient, communication being essential for this (LUCENA FILHO *et al.*, 2019).

Assertive communication is a competence that can be learned and trained which is defined as the expression of feelings, opinions, desires, ideas and preferences comfortably and objectively, without disrespecting the rights of others (KUBANY *et al.*, 1992; GRILO, 2012). Of the 7 attitudes pertaining to assertive communication, we deal with verbal attitudes in our stations (express their rights, showing empathy), consequential (expresses the effects of the other's behavior if he does not change it and gives him the opportunity to do so) and clarification (determines the rights of the other) (FERREIRA & ESTEVES, 2010). Learning to listen is essential to develop an adequate communication leading to an effective communication. Not being heard or being misinterpreted can lead to many conflicts in our lives, both personal and professional. For good communication, or assertive communication, the ability to listen and to put yourself in the other's shoes is fundamental, as it shows respect and allows an effective exchange of information (LEIRIA *et al.*, 2020). In order to establish a link with the knowledge of CMSE and the OSCE, we deal with the issues of patient autonomy and the principles of beneficence and non-maleficence (BEAUCHAMP & CHILDRESS, 2002) The results presented herein denote the contribution of the course, as it is currently structured, to the development of communication skills and to the applicability of medical ethical knowledge and, therefore, the regular to good performance for communication skills, the same is tolerable for the principles of patient autonomy and beneficence/non-maleficence. It is important to note that out of the 18 academics who answered the question correctly about autonomy in assessing CMSE knowledge, 10 (55.6%) presented an unsatisfactory performance in this category in the OSCE, reiterating our assumption that knowledge about CMSE although relatively adequate in general terms, needs improvement and association of this knowledge with practical scenarios and academic routines, and the current teaching model may be the main contributing factor to this problem, an assumption corroborated by the literature (DALPAI *et al.*, 2017; LEMOS *et al.*, 2017; PEREIRA *et al.*, 2019).

The fundamental points in the prevention of medical error that must be addressed in graduation are: improvement of the doctor-patient relationship and communication between doctors, patients and family members, valuing the doctor's social commitment, emphasis on continuing education and working in multidisciplinary teams, in addition to encouraging the correct filling of medical records (LESTER & TRITTER, 2001). Medical schools must incorporate the teaching of professionalism into the curriculum to ensure that the next

generations of doctors are prepared for compassionate, humanistic and ethical practice that is permeable to society's interest in a world of growing demands and in constant transformation. Advances in the development of 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 healthcare professionals who are ahead of the educational process. The trajectory of changes in focus in medical education where the structuring axis evolved 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. (SANTOS, 2018). In this sense, it is important to problematize the hegemonic models that influence values, interests, discourses, knowledge and practices, such as professionalism, throughout training. For this, the debate concerning evaluations/actions such as identity, diversity, inclusion, hegemony, ideology, power and culture, as well as the desirable values for a good professional, is fundamental. Such a debate can take place in a longitudinal and integrated way in curricular units related to the humanities, in the professional-user relationship, in interdisciplinarity, in social sciences, in psychology, among other contexts (SANTOS *et al.*, 2020).

Conclusion

The study showed that the knowledge of FAMERP medical clerkship students about the Code of Medical Students Ethics, although relatively adequate in general terms, lacks improvement and association of this knowledge to practical scenarios and academic routines, and the current teaching model can be the main contributing factor to this problem. Inefficiency was found especially during the clerkship, since there was no significant gain in knowledge during this period, in addition to a low rate of correct answers. Thus, there is a need for formal teaching of Medical Ethics during all undergraduate years, with an emphasis on structuring such teaching at the clerkship, since the current model, with a specific discipline only in one grade, has proved ineffective. As various other institutions have a similar teaching model, it is necessary to conduct more research with objectives and methods similar to this one, in order to expand comparisons in order to plan effective actions and minimize deficiencies in the teaching of Medical Ethics. The results presented herein denote the contribution of the course, as it is currently structured, to the development of communication skills and to the applicability of medical ethical knowledge and, thus, the regular to good performance for communication skills, the same is tolerable for the principles of patient autonomy and beneficence/non-maleficence

REFERENCES

- Abadel, F. T., & Hattab, A. S. 2014 Patients' assessment of professionalism and communication skills of medical graduates. *BMC Med Educ.* 14, pp. 28. <http://dx.doi.org/10.1186/1472-6920-14-28>
- Accreditation Council for Graduate Medical Education. 2016 Common programs requirements. Available online at: <https://www.acgme.org/acgmeweb/tabid/429/ProgramandInstitutionalAccreditation/CommonProgramRequirements.aspx>

- Amaral, A. B. C. N., Rider, E. A., Lajolo, P. P., Tone, L. G., Pinto, R. M. C., Lajolo, M. P., & Calhoun, A. W. 2016 Development of a Brazilian portuguese adapted version of the Gap-Kalamazoo communication skills assessment form. *Int J Med Educ.* 7, pp. 400-405. <http://dx.doi.org/10.5116/ijme.583a.df42>
- Amaral, F. T. V., & Troncon, L. E. A. 2007. Participation of medical students as examiners in an objective structured clinical examination. *Rev Bras Educ Med.* 311, pp. 81-89. <http://dx.doi.org/10.1590/S0100-55022007000100011>
- American College of Clinical Pharmacy., Roth, M. T., & Zlatic, T. D. 2009 Development of student professionalism. *Pharmacotherapy.* 296, pp. 749-756. <https://doi.org/10.1592/phco.29.6.749>
- Araújo, D. C. S. A., Menezes, P. W. S., Cavaco, A. M. N., Mesquita, A. R., & Lyra-Jr, D.P. 2020. Instruments for assessing communication skills in the area of healthcare in Brazil: a scoping review. *Interface Botucatu.* 24, pp. e200030. <http://dx.doi.org/10.1590/interface.200030>
- Baig, L. A., Violato, C., & Crutcher, R. A. 2009. Assessing clinical communication skills in physicians: are the skills context specific or generalizable. *BMC Med Educ.* 9, pp. 22. <https://doi.org/10.1186/1472-6920-9-22>
- Bastos, S. P., & Ferreira, A. P. 2019. The judicialization of health: the role of the judicial branch in signaling the need for development and implementation of public health policies. *Saúde Debate.* 43Spec. 4, pp. 48-0. <http://dx.doi.org/10.1590/0103-11042019s405>
- Batistella, P. M. F., Aroni, P., Fagundes, A. L., Haddad, M. C., & Fernandez, L. 2019 Lawsuits in health: an integrative review *Rev Bras Enferm.* 723, pp. 809-817. <https://doi.org/10.1590/0034-7167-2018-0551>
- Beardsley, R. S. 1996. Chair Report of the APhA-ASP/AACP-COD Task Force on Professionalization: Enhancing Professionalism in Pharmacy Education and Practice. Available online at <http://archive.ajpe.org/legacy/pdfs/aj600426S.pdf>
- Beauchamp, T. L. & Childress, J. F. 2002 *Princípios de Ética Biomédica.* Loyola, São Paulo SP, Brasil.
- Beauchamp, T. L. & Childress, J. F. 2002 *Princípios de Ética Biomédica.* Loyola, São Paulo SP, Brasil.
- Berenson, R. A. 2016 If You Can't Measure Performance, Can You Improve It? *JAMA.* 3157, pp. 645-646. <https://doi.org/10.1001/jama.2016.0767>.
- Bitencourt, A. G. V., Neves, N. M. B. C., Neves, F. B. C. S., Brasil, I. S. P. S., & Santos, L. S. C. 2007 Medical Error Analysis in Ethics Investigations: Implications on Medical Education. *Rev Bras Med Educ.* 312, pp. 166-172. <https://doi.org/10.1590/S0100-55022007000300004>
- Blackall, G. F., Melnick, S. A., Shoop, G. H., George, J., Lerner, S. M., Wilson, P. K., Pees, R.C., & Kreher, M. 2007 Professionalism in medical education: the development and validation of a survey instrument to assess attitudes toward professionalism. *Med Teach.* 292-3, pp. e58-62. <https://doi.org/10.1080/01421590601044984>.
- Bogo, M., Regehr, C., Katz, E., Logie, C., Tufford, L., & Litvack, A. 2012 Evaluating an Objective Structured Clinical Examination OSCE Adapted for Social Work. *Res SocWorkPract.* 224, pp. 428-436. <https://doi.org/10.1177/1049731512437557>
- Brasil. Ministério da Educação. Conselho Nacional de Educação. Câmara de Educação Superior. 2014 Resolução Nº. 3 de 20 de junho de 2014. Institui diretrizes curriculares nacionais do curso de graduação em Medicina e dá outras providências. Ministério da Educação, Brasília DF, Brasil. Available online at http://www.lex.com.br/legis_25663662_resolucao_n_3_de_20_de_junho_de
- Broadbent, J. 2007 If You Can't Measure it, How Can You Manage it? *Management and Governance in Higher Educational Institutions.* *Pub Money & Man.* 273, pp. 193-198. <http://dx.doi.org/10.1111/j.1467-9302.2007.00579.x>
- Burgess, A., Clark, T., Chapman, R., & Mellis, C. 2013 Medical student experience as simulated patients in the OSCE. *ClinTeach.* 104, pp. 246-250. <https://doi.org/10.1111/tct.12016>
- Bustamante, Z. M., Carvajal, H. C., Gottlieb, B. B., Contreras, P. J. E., Uribe, M. M., Melkonian, T. E., Cárdenas, S. P., Amadori, G. A., & Parra G. J. A. 2000. Objective Structured Clinical Examination for the evaluation of medical students. *Rev Méd Chile.* 1289, pp. 1039-1044. <http://dx.doi.org/10.4067/S0034-98872000000900013>
- Carneiro, M. A., Cunha, S. M., Feitosa, E. S., Sá, R. B., & Brilhante, A. V. M. 2020 Professionalism and its forms of assessment in medical students: An integrative review. *Interface Botucatu.* 24, pp. e190126. <https://doi.org/10.1590/interface.190126>
- Carvalho, R. R. P., & Cadidé, W. C. O. 2019 Litigious legal risks in health care. *Rev Enferm UFPE on line.* 13, pp. e242297. <https://doi.org/10.5205/1981-8963.2019.242297>
- Cendán, J. C., Castiglioni, A., Johnson, T. R., Eakins, M., Verduin, M. L. Asmar, A., Metcalf, D, & Hernandez, C. 2017 Quantitative and Qualitative Analysis of the Impact of Adoption of a Mobile Application for the Assessment of Professionalism in Medical Trainees. *11S Association of American Medical Colleges Learn Serve Lead: Proceedings of the 56th Annual Research in Medical Education Sessions,* pp. S33-S42. <https://doi.org/10.1097/ACM.0000000000001922>.
- Chalmers, R. K. 1997 Contemporary issues: professionalism in pharmacy. *Tomorrow Pharm.* , pp. 10-12.
- Cömert, M., Zill, J. M., Christalle, E., Dirmaier, J., Härter, M., & Scholl, I. 2016 Assessing communication skills of medical students in objective structured clinical examinations OSCE - A systematic review of rating scales. *PLoS One.* 113, pp. e0152717. <http://dx.doi.org/10.1371/journal.pone.0152717>
- Conover, W. J. 1998. *Practical nonparametric statistics.* John Wiley & Sons, New York NY, Brasil.
- Conselho Federal de Medicina. 2018 Código de ética do estudante de medicina. CFM, Brasília DF, Brasil.
- Conselho Federal de Medicina. 2019 Código de Ética Médica: Resolução CFM nº 2.217, de 27 de setembro de 2018 , modificada pelas Resoluções CFM nº 2.222/2018 e 2.226/2019. Conselho Federal de Medicina, Brasília DF, Brasil.
- Conselho Regional de Medicina do Distrito Federal. 2004 Código de ética do estudante de medicina. 3ª ed. CFM, Brasília DF, Brasil.
- Conselho Regional de Medicina do Estado de São Paulo. 2007. Código de ética do estudante de medicina. CREMSP, São Paulo SP, Brasil.
- Conselho Regional de Medicina do Estado de São Paulo. 2015. Código de Ética do Estudante de Medicina. Conselho Regional de Medicina do Estado de São Paulo ; Comissão de Pesquisa e Educação, São Paulo SP, Brasil

- Costa, F. H. 2019 O prontuário médico frente à judicialização da medicina. Available online at <http://pensaracademico.facig.edu.br/index.php/repositorioctcc/article/view/1832/1445>
- D'Acampora, A. J., Corrêa, G. 1996 Medical error, an approach. *Acta Cir Bras.* 111, pp. 42-46.
- Dalpai, D., Mendes, F. F., Asmar, J. A. V. N., Carvalho, P. L., Loro, F. L., & Branco, A. 2017 Pain and palliative care: the knowledge of medical students and the graduation gaps. *Rev Dor*, 184, pp. 307-310. <https://doi.org/10.5935/1806-0013.20170120>
- Dong, T., Kelly, W., Hays, M., Berman, N. B., & Durning, S. J. 2017 An investigation of professionalism reflected by student comments on formative virtual patient encounters. *BMC Med Educ.* 171, pp. 3. <https://doi.org/10.1186/s12909-016-0840-9>
- Dubai, H., Adelstein, B. A., Taylor, S., & Shulruf, B. 2019 Definition of professionalism and tools for assessing professionalism in pharmacy practice: a systematic review. *J Educ Eval Health Prof.* 16, pp. 22. <https://doi.org/10.3352/jeehp.2019.16.22>
- Duvivier, R. J., van Geel, K., van Dalen, J., Scherpbier, A. J. J. A., & van der Vleuten, C. P. M. 2012 Learning physical examination skills outside timetabled training sessions: what happens and why? *Adv Health Sci Educ Theory Pract.* 173, pp. 339-355. <https://doi.org/10.1007/s10459-011-9312-5>
- Ferreira, J., & Lapa Esteves, M. 2010. A peça que falta: comunicação. Available online at <https://www.redalyc.org/pdf/3498/349832327040.pdf>
- Field, A. 2009 Descobrimos a ESTATÍSTICA usando o SPSS. Artmed, São Paulo SP Brasil.
- Foucault, A., Dubé, S., Fernandez, N., Gagnon, R., & Charlin, B. 2015 Learning medical professionalism with the online concordance-of-judgment learning tool CJLT: A pilot study. *Med Teach.* 3710, pp. 955-60. <https://doi.org/10.3109/0142159X.2014.970986>
- Franco, C. A. G. S., Franco, R. S., Santos, V. M., Uieima, L. A., Mendonça, N. B., Casanova, A. P., Severo, M., & Ferreira, M. A. D. 2015 OSCE for Communication Skills and Professionalism: Case Report and Meta-Analysis. *Rev Bras Educ Med.* 393, pp. 433-441. <https://doi.org/10.1590/1981-52712015v39n3e02832014>
- Frank, J., Snell, L., & Sherbino, J. 2015 CanMEDS 2015 physician competency framework. Available online at www.royalcollege.ca/rcsite/documents/canmeds/canmeds-full-framework-e.pdf
- Godoy, M. F., Ferreira, H. R. A., & Dalla Pria, O. A. F. 2014 Avaliação do conhecimento da ética médica dos graduandos de medicina. *Rev Bras Educ Med.* 381, pp. 31-37. <http://dx.doi.org/10.1590/S0100-55022014000100005>
- Godoy, M. F., Ferreira, H. R. A., & Pria, O. A. F. D. 2014 Avaliação do conhecimento da ética médica dos graduandos de medicina. *Rev Bras Educ Med.* 381, pp. 31-37. <http://dx.doi.org/10.1590/S0100-55022014000100005>
- Gomes, J. C. M., & França, G. V. 1998 Erro médico. In: Costa, S. I. F., Garrafa, V., & Oselka, G. Iniciação à bioética. CFM, Brasília DF, Brasil. pp. 243-258.
- Goss, B. D., Ryan, A. T., Waring, J., Judd, T., Chiavaroli, N. G., O'Brien, R. C., Trumble, S. C., & McColl, G. J. 2017 Beyond Selection: The Use of Situational Judgement Tests in the Teaching and Assessment of Professionalism. *Acad Med.* 926, pp. 780-784. <https://doi.org/10.1097/ACM.0000000000001591>
- Grilo, A. M. 2012. Relevance of assertiveness in health care professional-patient communication. *Psicol Saúde & Doenças.* 132, pp. 283-297. <https://doi.org/10.15309/12psd130210>
- Grisard, N. 2002. Ética Médica e Bioética: a disciplina em falta na graduação médica. Available online at https://revistabioetica.cfm.org.br/index.php/revista_bioetica/article/view/200/203
- Guerra, J., & Nepomuceno, M. Teaching empathic communication in medical graduation in a Pernambuco college. Available online at <https://www.periodicos.univasf.edu.br/index.php/revasf/article/download/1031/794>
- Gupta, P., Dewan, P., & Singh, T. 2010 Objective Structured Clinical Examination OSCE Revisited. *Indian Pediatr.* 4711, pp. 911-920. <https://doi.org/10.1007/s13312-010-0155-6>
- Hammer DP. 2000 Professional Attitudes and Behaviors: The "A's and B's" of Professionalism Galley. *Am J Pharm Educ.* 64, pp. 455-464. <https://doi.org/aj640420>
- Hammer, D. P., Berger, B. A., Beardsley, R. S., & Easton, M. R. 2003 Student Professionalism. Available online at <https://pharmacy.utah.edu/pep/preceptors/professionalism-article.pdf>
- Hammer, D. P., Mason, H. L., Chalmers, R. K., Popovich, N. G., & Rupp, M. T. 2000 Development and Testing of an Instrument to Assess Behavioral Professionalism of Pharmacy Students. Available online at <http://archive.ajpe.org/legacy/pdfs/aj640206.pdf>
- Hebert, P. C., Meslin, E. M., Dunn, E. V., & Reid, S. R. 1992 Measuring the ethical sensitivity of medical students: a study at the University of Toronto. *J Med Ethics.* 183, pp. 142-147. <http://dx.doi.org/10.1136/jme.18.3.142>
- Hoppe, R. B., King, A. M., Mazor, K. M., Furman, G. E., Wick-Garcia, P., Corcoran-Ponisciak, H., & Katsufakis, P. J. 2013 Enhancement of the assessment of physician-patient communication skills in the United States medical licensing examination. *Acad Med.* 8811, pp. 1670-1675. <http://dx.doi.org/10.1097/ACM.0b013e3182a7f75a>
- Hrisos, S., Eccles, M. P., Francis, J. J., Dickinson, H. O., Kaner, E. F., Beyer, F., & Johnston, M. 2009 Are there valid proxy measures of clinical behaviour? A systematic review. *Implement Sci.* 4, pp. 37. <https://doi.org/10.1186/1748-5908-4-37>
- Hultmann C. S., & Wagner, I. J. 2015 Professionalism in plastic surgery: attitudes, knowledge, and behaviors in medical students compared to surgeons in training and practice--one, but not the same. *Ann Plast Surg.* 74 Suppl 4, pp. S247-54. <https://doi.org/10.1097/SAP.0000000000000450>
- Humphris, G. M. 2002 Communication skills knowledge, understanding and OSCE performance in medical trainees: a multivariate prospective study using structural equation modelling. *Med Educ.* 369, pp. 842-852. <https://doi.org/10.1046/j.1365-2923.2002.01295.x>
- Jha, V., Bekker, H. L., Duffy, S. R. G., & Roberts, T. E. 2007 A systematic review of studies assessing and facilitating attitudes towards professionalism in medicine. *Med Educ.* 418, pp. 822-829. <http://dx.doi.org/10.1111/j.1365-2923.2007.02804.x>
- Kalet, A., Buckvar-Keltz, L., Monson, V., Harnik, V., Hubbard, S., Crowe, R., Ark, T. K., Song H. S., Tewkssoon, L., & Yingling, S. 2018 Professional Identity Formation in Medical School: One measure reflect

- changes during pre-clerkship training. Available online at <https://www.mededpublish.org/manuscripts/1454>
- Kfoury Neto, M. 1999 Responsabilidade civil do médico. Ed. Revista de Tribunais, São Paulo SP, Brasil.
- Khan, K. Z., Gaunt, K., Ramachandran, S., & Pushkar, P. 2013 The Objective Structured Clinical Examination OSCE: AMEE Guide No. 81. Part II: organisation & administration. *Med Teach.* 359, pp. e1447-e1463. <https://doi.org/10.3109/0142159X.2013.818635>
- Kubany, E. S., Richard, D. C., Bauer, G. B., & Muraoka, M. Y. 1992. Impact of assertive and accusatory communication of distress and anger: A verbal component analysis. *Aggressive Beh.* 185, pp. 337-347. <https://doi.org/10.1002/1098-2337199218:5<337::AID-AB2480180503>3.0.CO;2-K>
- Leiria M., Correia, I., Pinto, M., & Galvão, S. 2020. A aplicabilidade da comunicação na psicologia. *Rev INFAD Psicol.* 11, pp. 435-442. <https://doi.org/10.17060/ijodaep.2020.n1.v1.1805>
- Lemos, C. F. P., Barros, G. S., Melo, N. C. V., Amorim, F. F., & Santana, A. N. C. 2017 Evaluation of Medical Students' Knowledge of Palliative Care. *Rev Bras Educ Med.* 412, pp. 278-282. <https://doi.org/10.1590/1981-52712015v41n2rb20160087>
- Lemos, K., Neves, N., Athanazio, R., Lordelo, M., Bitecourt, A., Neves, F. S., Boaventura, C., & Nery Filho, A. 2005. Proposal of an Ethics Code for the Medical Students in Bahia. Available online at http://www.gmbahia.ufba.br/adm/arquivos/artigo03_2005_2.pdf
- Lester, H., & Tritter, J. Q. 2001 Medical error: a discussion of the medical construction of error and suggestions for reforms of medical education to decrease error. *Med Educ.* 359, pp. 855-861. <http://dx.doi.org/10.1046/j.1365-2923.2001.01003.x>
- Liboni, M., & Siqueira, J. E. 2009 Competência moral do estudante de medicina. *Rev Assoc Med Bras.* 552, pp. 226-228. <http://dx.doi.org/10.1590/S0104-42302009000200031>
- Lind, G. 2000 Moral regression in medical students and their learning environment. *Rev Bras Educ Med.* 243, pp. 24-33.
- Lisboa, L., & Lins, L. 2014 Code of ethics of medical student: a qualitative analysis. *RevBioét.* 221, pp. 182-190. <https://doi.org/10.1590/S1983-80422014000100021>
- Lucena Filho, E. L., Novais, L. C., & Pinto, G. A. Compreensão do Universo Linguístico e seus Reflexos na Saúde. Available online at <http://repositorio.pgsskroton.com/bitstream/123456789/23794/1/01%20-%20Compreens%C3%A3o%20do%20universo.pdf>
- Marwaha, S. 2011 Objective Structured Clinical Examinations OSCEs, psychiatry and the Clinical assessment of Skills and Competencies CASC same evidence, different judgement. *BMC Psychiatry.* 11, pp. 85. <https://doi.org/10.1186/1471-244X-11-85>
- Mendonça, A. C., Villar, H. C. C. E., Tsuji, S. R. 2009 Medical students' knowledge concerning physician responsibility and patient confidentiality at the Marília School of Medicine in São Paulo State, Brazil. *Rev Bras Educ Med.* 332, pp. 221-229. <http://dx.doi.org/10.1590/S0100-55022009000200009>
- Menezes, M. M., Amaral, F. R., Rocha, C. U., Ribeiro, C. R., Maia, L. C., Sampaio, C. A., & Costa, S. M. 2017 Collective drafting of the medical student's code of ethics. *RevBioét.* 251, 179-190. <https://doi.org/10.1590/1983-80422017251179>
- Mesquita, A. R., Santos, E. A., Porto, J. G., Barros, I. M. C., & Lyra, D. P. 2012 Translation in Brazilian Portuguese and content validation of the instrument "avaliação do processo de atendimento farmacêutico". *Lat Am J Pharm.* 3110, pp. 1422-1429.
- Monrouxe, L. V., Rees, C. E., Dennis, I., & Wells, S. E. 2015 Professionalism dilemmas, moral distress and the healthcare student: insights from two online UK-wide questionnaire studies. *BMJ Open.* 2015 May 19;55:e007518. <https://doi.org/10.1136/bmjopen-2014-007518>
- Moreto, G., Federici, V. P., Silva, V. R., Pacheco, F. M., & Blasco, P. G. 2018 Professionalism and medical training of excellence: Challenges found in the academy and in clinical practice. Available online at <https://www.medigraphic.com/pdfs/medfam/amf-2018/amf184e.pdf>
- Mueller, P. S. 2015 Teaching and Assessing Professionalism in Medical Learners and Practicing Physicians. *RambamMaimonidesMed J.* 62, pp. e0011. <https://doi.org/10.5041/RMMJ.10195>
- Mylrea, M. F., Gupta, T. S., & Glass, B. D. 2015 Professionalization in Pharmacy Education as a Matter of Identity. *Am J Pharm Educ.* 799, pp. 142. <https://doi.org/10.5688/ajpe799142>
- Nascimento, A. C., Baptista, G. A. G., Rocha, G. A., Ferreira, H. A., Biasotto, I. B., Nogueira, J. A., Pina, N. R. L., Sabdin, P., Mariz, R. F. L. A., Quineper, R. N., & Souza, E. A. L. 2020 Erro médico e prevenção de ações judiciais: Análise dos deveres anexos na relação médico-paciente para além da assistência técnica. *Braz J Hea Rev.* 34, 8717-8731. <https://doi.org/10.34119/bjhrv3n4-117>
- Nunes, G. F., Guimarães, T. F., Pargeon, J. P. O. M., Bastos, G. C. F. C., Silva, A. M. T. C., & Almeida, R. J. 2020. Analysis of Empathy Levels of Teachers and Medical Preceptors of a Medical Course. *Rev Bras Educ Med.* 441, pp. e043. <https://doi.org/10.1590/1981-5271v44.1-20190107>
- O'Sullivan, A. J., & Toohey, S. 2008 Assessment of professionalism in undergraduate medical students. *Med Teach.* 303, pp. 280-286. <http://dx.doi.org/10.1080/01421590701758640>
- Oliveira, A. F. M., Faraco, C. B., Miranda, C. S., & Guyoti, V. M. 2017. Pensar a comunicação em programas de intervenção comunitária na área da saúde. *Rev Educ Contin Med Vet Zootec do CRMV-SP.* 151, pp. 85-85.
- Oliveira, G. P. T. C., Ribeiro, D. P. S., & Alexandre, M. R. C. 2020 Bioética e política no estado do Tocantins: dilemas éticos de justiça na judicialização da saúde. Available online at <https://revista.unitins.br/index.php/humanidadeseinovacao/article/view/1790/1377>
- Papadakis, M. A., Hodgson, C. S., Teherani, A., & Kohatsu, N. 2004 Unprofessional behavior in medical school is associated with subsequent disciplinary action by a State Medical Board. *Acad Med.* 793, pp. 244-249. <http://dx.doi.org/10.1097/00001888-200403000-00011>
- Park, S. Y., Shon, C., Kwon, O. J., Yoon, T. Y., & Kwo, I. 2017. A qualitative thematic content analysis of medical students' essays on professionalism. *BMC Med Educ.* 171, pp. 79. <https://doi.org/10.1186/s12909-017-0920-5>
- Patenaude, J., Niyonsenga, T., & Fafard, D. 2003 Changes in students' moral development during medical school: a

- cohort study. Available online at <https://www.cmaj.ca/content/cmaj/168/7/840.full.pdf>
- Pereira, E. A. L., Rangel, A. B., & Giffoni, J. C. G. 2019 Identifying the Level of Knowledge in Palliative Care among Medical Students in Goiás. *Rev Bras Educ Med.* 434, pp. 65-71. <http://dx.doi.org/10.1590/1981-52712015v43n4rb20180116>
- Pereira, T. J., Puggina, A. C. 2017 Validation of the self-assessment of communication skills and professionalism for nurses. *Rev Bras Enferm.* 703, pp. 588-594. <http://dx.doi.org/10.1590/0034-7167-2016-0133>
- Piccini, R. X. 1997 Avaliação do ensino médico no Brasil, entre 1991 e 1997: relatório geral. CINAEN, Brasília DF, Brasil.
- Prearo, A. Y., Monti, F. M. F., & Barragan, E. 2012 Is it possible for first year students working in the community to develop self-reflection? preliminary Study. *Rev Bras Educ Med* 361, pp. 24-31. <http://dx.doi.org/10.1590/S0100-55022012000100004>
- Puggina, A. C., & Silva, M. J. P. 2014 Interpersonal Communication Competence Scale: Brazilian translation, validation and cultural adaptation. *Acta Paul Enferm.* 272, 108-114. <http://dx.doi.org/10.1590/1982-0194201400020>
- Ract, A. L. P., & Maia, J. A. 2012 Reflection on four versions of the ethics code of the medical student. Available online at https://revistabioetica.cfm.org.br/index.php/revista_bioetica/article/view/771/823
- Randall, V. F., Foster, C. W., Olsen, C. H., Warnick, A. B., Fernandez, K. A., Crouch, G. 2016 Defining Medical Professionalism Across the Years of Training and Experience at the Uniformed Services University of the Health Sciences. *Mil Med.* 18110, pp. 1294-1299. <https://doi.org/10.7205/MILMED-D-15-00438>
- Rego, S. 2003 A formação ética dos médicos: saindo da adolescência com a vida dos outros nas mãos. FIOCRUZ, Rio de Janeiro RJ, Brasil.
- Rocha, S. R., Romão, G. S., Setúbal, M. S. V., Collares, C. F., & Amaral, E. 2019. Assessment of Communication Skills in the Simulated Environment of Medical Training: Concepts, Challenges and Possibilities in Medical Education. *Rev Bras Educ Med.* 431, pp. 236-245. <https://doi.org/10.1590/1981-5271v43suplemento1-20190154>
- Sánchez Gómez, S., Ostos, E. M. C., Solano, J. M. M., & Salado, T. F. H. 2013 An electronic portfolio for quantitative assessment of surgical skills in undergraduate medical education. *BMC Med Educ.* 13, pp. 65. <http://dx.doi.org/10.1186/1472-6920-13-65>
- Sandoval, G. E., Valenzuela, P. M., Monge, M. M., Toso, P. A., Triviño, X. C., Wright, A. C., Paris, E., Sánchez, I., & Vladiviva, G. S. 2010 Analysis of a learning assessment system for pediatric internship based upon objective structured clinical examination, clinical practice observation and written examination. *J Pediatr Rio J.* 862, pp. 131-136. <https://doi.org/10.1590/S0021-75572010000200009>
- Santos, V. H., Ferreira, J. H., Alves, G. C. A., Naves, N. M., Oliveira, S. L., Raimondi, G. A., & Paulino, D. B. 2020 Hidden curriculum, medical education, and professionalism: an integrative review. *Interface Botucatu.* 24, pp. e190572. <https://doi.org/10.1590/interface.190572>
- Santos, W. F. S. Profissionalismo médico – cuidando da formação profissional Do estudante de medicina. Available online at <https://cdn.publisher.gn1.link/rbm.org.br/pdf/v55a07.pdf>
- Sattar, K., Roff, S., & Meo, S. A. 2016. Your professionalism is not my professionalism: congruence and variance in the views of medical students and faculty about professionalism. *BMC Med Educ.* 161, pp. 285. <https://doi.org/10.1186/s12909-016-0807-x>
- Schirmer, J. M., Mauksch, L., Lang, F., Marvel, M. K., Zoppi, K., Epstein, R. M., Brock, D., & Pryzbylski, M. 2005. Assessing communication competence: a review of current tools. Available online at <https://fammedarchives.blob.core.windows.net/imagesandpdfs/fmhub/fm2005/March/Julie184.pdf>
- Siegel, S., Castellan Jr, N. J. 2006 *Estatística Não Paramétrica para Ciências do Comportamento*. Bookman, São Paulo SP, Brasil.
- Thurston, M. M., Augustine, J., & Bonner, C. L. 2018. A comparison of baseline professional attitudes and behaviors among student pharmacists to inform a co-curricular professional engagement program. *Curr Pharm Teach Learn.* 107, pp. 875-885. <https://doi.org/10.1016/j.cptl.2018.04.007>
- Tucker, C. R., Choby, B. A., Moore A., Parker, R. S., Zambeti, B. R., Naidu, S., Scott, J., Loomer, J., & Gaffney, S. 2016. Speaking up: using OSTEs to understand how medical students address professionalism lapses. *Med Educ Online.* 21, pp. 32610. <https://doi.org/10.3402/meo.v21.32610>
- Ventura, M., Simas, L., Pepe, V. L. E., & Schramm, F. R. 2010 Judicialization of the right to health, access to justice and the effectiveness of the right to health. *Physis.* 201, pp. 77-100. <https://doi.org/10.1590/S0103-73312010000100006>
- Whitehead, J., Shaver, J., & Stephenson, R. 2016 Outness, Stigma, and Primary Health Care Utilization among Rural LGBT Populations. *PLoS One.* 111, pp. e0146139. <https://doi.org/10.1371/journal.pone.0146139>
- Wilkinson, T. J., Wade, W. B., & Knock, L. D. 2009 A blueprint to assess professionalism: results of a systematic review. *Acad Med.* 845, pp. 551-558. <https://doi.org/10.1097/ACM.0b013e31819fbaa2>
- Ziring, D., Danoff, D., Grosseman, D. L., Esposito, A., Jan, M. K., Rosenzweig, S., & Novack, D. 2015. How Do Medical Schools Identify and Remediate Professionalism Lapses in Medical Students? A Study of U.S. and Canadian Medical Schools. *Acad Med.* 907, pp. 913-920. <https://doi.org/10.1097/ACM.0000000000000737>
