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Research Article

Palliative care: is undergraduate teaching sufficient for primary health care in Brazil?

Cuidados paliativos: o ensino na graduação é suficiente para a atuação na atenção primária à saúde no Brasil?

Cuidados paliativos: ¿es suficiente la docencia de pregrado para la atención primaria de salud en Brasil?

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Abstract

Introduction: It is expected that the increase in the burden of chronic diseases and population aging will result in a growing demand for palliative care in the country. Despite this, there is still a deficit in Brazil in the teaching of the area, seen above all in the scarcity of its approach in medical school, as well as in other areas of health. This scenario translates into a weak training of health professionals, especially physicians, impacting the necessary care of patients with potentially life-threatening clinical conditions in all contexts, including primary health care. **Objectives:** This study aimed to analyze the overview of palliative care teaching in Brazil and its implication in the training of general practitioners and in the quality of care provided in primary health care. It also aimed to identify the necessary skills for teaching palliative care in medical school. **Methods:** This is an integrative review of the national literature on the teaching of palliative care in medical schools in Brazil and its implications for adapting to practice in primary health care. **Results:** Of the analyzed studies, all of them emphasized the importance of approaching palliative care in professional basic training in medical school and reveal the existence of gaps to be filled in this teaching area. Among the gaps identified were low approach in curriculum grids, inappropriate teaching methodologies and little specialization of instructors. From this, some Brazilian studies built curricular proposals based on mapping minimum skills in an attempt to remedy these gaps, including communication skills and the medical attitude towards the death process. This article compiles the main skills for teaching palliative care in medical school found for the Brazilian context. **Conclusions:** The weakness of teaching palliative care in medical school results in general practitioners lacking basic skills for this type of care, which occupies an increasingly prominent place in everyday primary health care. This weakness needs to be urgently addressed to adapt to the population's needs, particularly in SUS, because of the number of family and community physicians falling short of the needs of primary health care in Brazil.

Keywords: Palliative care; Medical education; Medical graduate education; Students; Primary health care.

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Resumo

Introdução: Espera-se que o aumento da carga de doenças crônicas e do envelhecimento populacional repercuta em crescente demanda por cuidados paliativos no país. Apesar disso, no Brasil ainda há um déficit no ensino da área, visto sobretudo na escassez de sua abordagem na graduação em Medicina, assim como em outras áreas da saúde. Esse cenário traduz-se em uma formação frágil dos profissionais da saúde, principalmente médicos, impactando o cuidado necessário a pacientes com condições clínicas potencialmente ameaçadoras da vida em todos os contextos, incluindo a atenção primária à saúde. **Objetivos:** Este estudo objetiva analisar o panorama de ensino de cuidados paliativos no Brasil e sua implicação na formação do médico generalista e na qualidade dos cuidados prestados na atenção primária à saúde. Também objetiva identificar competências necessárias para o ensino de cuidados paliativos na graduação de Medicina. **Métodos:** Trata-se de uma revisão integrativa da literatura nacional a respeito do ensino de cuidados paliativos nas escolas médicas do Brasil e suas implicações na adequação à prática na atenção primária à saúde. **Resultados:** Dos estudos analisados, todos ressaltam a importância da abordagem dos cuidados paliativos na formação de base profissional na graduação e revelam a existência de lacunas a serem supridas nessa área de ensino. Entre as lacunas foram identificadas baixa abordagem nas grades curriculares, metodologias de ensino não adequadas e pouca especialização dos docentes. Com base nisso, alguns estudos brasileiros construíram propostas curriculares baseadas em mapeamento de competências mínimas na tentativa de sanar essas lacunas, incluindo habilidades de comunicação e a atitude médica diante do processo de morte. Este artigo compila as principais competências para o ensino de cuidados paliativos na graduação encontradas para o contexto brasileiro. **Conclusões:** A fragilidade do ensino de cuidados paliativos na graduação médica resulta em médicos generalistas carentes de competências básicas para esse tipo de cuidado, o qual ocupa cada vez mais lugar de destaque no cotidiano da atenção primária à saúde. Essa fragilidade precisa ser urgentemente abordada a fim de se adequar às necessidades populacionais, particularmente no Sistema Único de Saúde (SUS), dado o quantitativo de médicos de família e comunidade aquém das necessidades da APS brasileira.

Palavras-chave: Cuidados paliativos; Educação médica; Graduação em medicina; Estudantes; Atenção primária à saúde.

Resumen

Introducción: Se espera que el aumento de la carga de enfermedades crónicas y el envejecimiento poblacional se traduzcan en una creciente demanda de cuidados paliativos en el país. A pesar de eso, en Brasil todavía hay un déficit en la enseñanza del área, visto sobre todo en la escasez de su abordaje en la graduación médica, así como en otras áreas de la salud. Este escenario se traduce en una frágil formación de los profesionales de la salud, especialmente de los médicos, impactando en la atención necesaria a los pacientes con condiciones clínicas potencialmente mortales en todos los contextos, incluida la atención primaria de salud. **Objetivos:** Este estudio tiene como objetivo analizar el panorama de la enseñanza de cuidados paliativos en Brasil y su implicación en la formación de médicos generales y en la calidad de la atención prestada en la atención primaria de salud. También tiene como objetivo identificar las habilidades necesarias para la enseñanza de los cuidados paliativos en la graduación médica. **Métodos:** Estudio basado en una revisión integradora de la literatura nacional sobre la enseñanza de cuidados paliativos en las facultades de medicina de Brasil y sus implicaciones para la adaptación a la práctica en la atención primaria de salud. **Resultados:** De los estudios analizados, todos destacan la importancia del abordaje de los cuidados paliativos en la formación profesional a nivel de pregrado y revelan la existencia de vacíos a ser llenados en esta área de enseñanza. Entre los vacíos se identificaron bajo enfoque en las mallas curriculares, metodologías de enseñanza inadecuadas y poca especialización de los docentes. A partir de eso, algunos estudios brasileños construyeron propuestas curriculares basadas en el mapeo de competencias mínimas en un intento de remediar estas brechas, incluyendo las habilidades de comunicación y la actitud médica frente al proceso de muerte. Este artículo recopila las principales competencias para la enseñanza de cuidados paliativos en la graduación encontradas para el contexto brasileño. **Conclusiones:** La fragilidad de la enseñanza de los cuidados paliativos en la carrera de medicina hace que los médicos generales carezcan de las competencias básicas para este tipo de atención, que ocupa un lugar cada vez más destacado en el cotidiano de la atención primaria de salud. Esa fragilidad necesita ser atendida con urgencia para adaptarse a las necesidades de la población, particularmente en el SUS, debido a la cantidad de médicos familiares y comunitarios que no alcanzan las necesidades de la APS brasileña.

Palabras clave: Cuidados paliativos; Educación médica; Graduación médica; Estudiantes; Atención primaria de salud.

INTRODUCTION

According to the definition of the World Health Organization (WHO), palliative care is an approach that aims to improve the quality of life of patients (and their families) who face adversities associated with limiting and potentially fatal diseases, in a multidisciplinary field of action.[1] Globally, it is estimated that around 12% of patients who need palliative care (PC) actually receive it.[2] For such an inadequate supply, the WHO raised three main obstacles: frequency of national health policies and systems that do not include PC; training for health professionals is usually limited or non-existent; inadequate population access to opioids and without meeting international conventions on access to essential medicines.[1]

In Brazil, there is a lack of knowledge about the concepts and applications of PC, both among doctors and other health professionals, hospital managers and the judiciary. As a complicating factor for this panorama of lack of knowledge, PC activities have not yet been standardized in the country, according to the National Academy of Palliative Care (ANCP).[3] One of the reasons for this lack of knowledge is the training of health professionals in the country. Despite there being an alignment of the skills provided for by the National Curricular Guidelines (DCN) for Medicine courses with the internationally recognized skills for carrying out palliative care, there is still an educational gap, especially in the curricular structures in the undergraduate context, which do not teach how to recognize symptoms and how to deal with a terminal patient in a humane and active way.[4]

The reflection of this scenario can be verified, for example, by the index on the quality of death, related to PC, carried out by The Economist Intelligence Unit in 2015, which placed Brazil in 42nd place in the general ranking of 80 countries. In this same ranking, in the category of ability to carry out PC, Brazil ranked 64th.[5]

Such results are partly due to weaknesses in the training process of health professionals. According to ANCP, in 2018, of the total of 302 undergraduate medicine courses in the country, 42 (14%) had a PC subject, which was mandatory in only 18 courses (6%).[6] In 2021, of the 315 medical schools registered with the Ministry of Education, 44 had the subject in their curriculum.[7]

PC can be offered in different health care contexts, from home to hospital, through different levels of health care and involving different professionals. This care can be more general, focused on multidisciplinary monitoring and assistance and with less need for support from supplies and equipment, such as what occurs in primary care. On the other hand, it can acquire the specificities of highly specialized care that depends on greater technological density, such as care for patients with complex clinical needs at the hospital level. Ideally, palliative care should be offered by these different profiles and in an integrated manner.

Although the largest supply of PC services in Brazil is still concentrated in hospitals,[6] primary health care (PHC) has increasingly gained prominence in the coordination of PC in the country. PHC is strategic because of its potential impact on the population, in addition to the lower cost of its services when compared to the hospital level. This impact occurs in the first dimension because of the role of PHC as a gateway to the health care network, seen most frequently in the Unified Health System (SUS). Additionally, PHC is ideally responsible for assisting the population's most prevalent conditions, including chronic diseases, throughout the individual's life cycle and also following attributes such as longitudinality and comprehensiveness of care.

Added to these dimensions is its potential organizational role in the context of PC, foreseen in documents published by the Ministry of Health, such as the National Primary Care Policy (2017),[8] which establishes PHC as the system's organizer; Ordinance No. 963, of 2013,[9] which describes the role of PHC in home care in PC; and, finally, by Resolution No. 41, of 2018, which deals with the guidelines for the organization of PC, in light of continued care integrated into the SUS.[10]

Furthermore, multidisciplinary teamwork and action beyond the physical environment of Health Units, including care in the community and at home, are everyday practices in primary care, which brings a favorable outlook for the practice of PC in the context of PHC.[7] Finally, it is worth highlighting that one of the challenges highlighted by the WHO for the adequate provision of PC in different countries lies in the weakness of adequate pain management, one of the most prevalent clinical symptoms in patients indicated for PC. The practice of this management then becomes one of the essential competencies for

the area, something also already included in the daily life of PHC. The prevalence of patients with chronic pain in PHC is the main complaint in 40% of consultations, which favors practices of rational use of public resources and drugs.[11]

All of this data give PHC a potential leading role in expanding the supply of PC in the country. However, to this end, there is still the challenge of weakness in the training of professionals in identifying, managing and planning the provision of this care in PHC practice.[12] The family and community doctor is the most qualified professional to work in the context of PHC, bringing in its specialized training skills to face the challenges already mentioned. However, there is still a huge shortage of professionals adequately trained through medical residency in the country. In 2022, there were more than 52,500 teams registered to work in PHC within the scope of the SUS, but only 11,255 family doctors registered in the country.[13-14] These data are more worrisome considering that some of these specialist doctors are allocated to jobs in the supplementary and/or private health care.

PC requires investments, including in basic medical training and specialized training, which will be translated in the long term into lower health costs and better results, as seen in countries that are at the top of the Quality of Death ranking after expanding such services.[5]

Based on this, in the present study, we carried out a literature review, exploring the overview of PC teaching in medical training and for PHC in Brazil and its gaps.

METHODS

A non-systematic integrative review of the literature was carried out, following the steps of problem identification, definition of terms and search strategies, literature search, data evaluation, data analysis, synthesis of results and discussion.[15]

The problem identified was the adequacy of PC teaching in medical schools in Brazil, considering the WHO guidelines and PHC practice in the country. The literature search was focused on scientific productions with a Brazilian research context carried out in the Scientific Electronic Library Online (SciELO) and Virtual Health Library (VHL) databases, using broad search terms in Portuguese and English. The last access date to the databases occurred in August 2022.

The keywords and search strategy used in Portuguese were the combination: (cuidados paliativos) AND (ensino or educação médica OR graduação em medicina OR estudante); and the combination (cuidados atenção básica paliativos) AND (atenção primária à saúde OR atenção básica). The keywords and search strategy used in English were the combination (palliative care) AND (teaching OR medical education OR medical undergraduate OR student) and the combination (palliative care) AND (primary health care).

The selection of studies involved the inclusion of original and review articles relating to the topic covered, with a focus on the Brazilian scenario, published between 2017 and 2021. This period delimitation considered the potential dynamics of curricular changes in medical schools. Studies carried out in Brazil and focusing on the PC teaching scenario in the country were included. Works that did not have the aforementioned keywords or that, in their title or summary, did not include the topic studied or studies in areas of health other than medicine or carried out outside Brazil were excluded. Articles published only in English were also excluded.

The analysis of the studies was initially carried out by reading the titles and abstracts and, subsequently, the selected articles were read in full and through critical evaluation, focusing on their

relevance to the identified problem. For the analysis and synthesis of articles that met the inclusion criteria, a table was developed in Microsoft Office Excel 2016 software, which includes the following variables: article title, authors, journal, type/approach of the study, objective/question of investigation and results.

The results will be presented in a descriptive way, highlighting the two main dimensions of analysis: overview of PC teaching in Brazilian medical schools and synthesis of the mapping of skills for PC teaching in the country.

Additionally, a quick review was carried out in the international literature and on official websites of interest to the study, such as the WHO, the National Academy of Palliative Care and the Brazilian Society of Family and Community Medicine (SBMFC), to explore data important for discussing the findings of the base studies of the integrative review.

RESULTS

The literature review retrieved 56 records, of which 20 were selected after evaluating the inclusion and exclusion criteria for in-depth reading. Two articles were excluded after this stage because they did not align with the research context, focusing on teaching PC in the context of medical training. In the end, 18 bibliographic sources were obtained to extract the main results. In general, all highlight the importance of PC since medical school and the existence of gaps to be filled. In addition to reinforcing the importance of teaching, six works raise suggestions for skills and topics to be included in PC teaching in medical training (undergraduate). The synthesis of articles will address these two main findings.

Overview of teaching palliative care in medical schools in Brazil

Of the studies reviewed, seven directly cited the assessment of medical students regarding their knowledge about PC, mainly highlighting the difficulty in developing communication skills and medical attitude towards the death process.

Kanashiro et al.[16] evaluated the gain of PC skills among medical students enrolled in a technology-mediated PC discipline. A significant gain in skills was noticed after technology-mediated teaching (EMT), especially those involving general concepts, symptom management and bioethics. However, in skills such as communication and teamwork, there was no significant increase in scores.[16]

The cross-sectional study by Orth et al.[17] resulted in adequate knowledge of the students. However, 50% of those assessed reported being unprepared to deal with the death of a patient and the family members' grieving process. Furthermore, 80.3% said they did not have the communication skills and medical attitude to communicate bad news.[17]

In a cohort study carried out at Universidade São Francisco, which compared the impact of theoretical and practical contact with the PC discipline during medical training, the results had statistical significance, demonstrating that theoretical reflection reduces anxiety related to practice and that knowledge skills communication and multidisciplinary work in PC are better performed by those who received joint training, compared to groups with exclusive training (only theoretical or only practical).[18]

Next, among the studies reviewed, 15 refer to curricular proposals for better elaboration of PC teaching in medical schools. These initiatives appeared after the publication of the National Curricular Guidelines (DCN) in 2014, which emphasize the inclusion of the terms “death” and “end of life” in their principles. Although this measure has boosted the teaching of PC in medical undergraduate courses, only 14% of medical schools in the country include PC in their curriculum,[7,13,19-22] and only 5% have a subject entirely focused on PC.[20,21]

Souza et al.[23] demonstrated that the majority of medical students have little or no pedagogical support during their undergraduate studies and learn to deal with situations of suffering and terminal illness in practice. This weak learning translates into discomfort in dealing with the processes of death and dying, as well as the appearance of feelings of anguish, discomfort and unpreparedness throughout medical training.[23,24] A study in an educational institution in Goiás corroborates this question, stating that topics discussed in medical scchool focused little on clinical practice.[25]

Castro et al.[7] carried out an important study in 2021 with the objective of evaluating the inclusion of content related to PC in all 315 medical schools registered with the Ministry of Education. The study revealed that only 14% of courses have a PC subject and, of these, the predominant type of subject was mandatory in 61% of schools and optional in the others. Furthermore, it was identified that the predominant setting is the classroom and few institutions provide teaching-service-community integration and medical practice.[7]

Regarding the specialization and qualification of instructors, in the study by Souza et al.[23] and Correia et al.,[20] most instructors reported difficulty in dealing with the topic and even avoided it. Correia et al.[24] state that there is still a fear among some that supportive treatment will be misinterpreted, confused with euthanasia or that it could lead to death itself, bringing anguish and fears, but the study showed that instructors changed their view after the teaching experience.[17] Furthermore, the absence of a PC clinical service means that the institution has reduced interest, with insufficient funds and a shortage of time and teaching material.[20]

Skills for teaching palliative care

Castro et al.,[26] in a systematic review, observed that the curricular matrices are varied, as the learning objectives for PC in medical education are not yet well defined and the acquisition of knowledge in general is leveraged with the insertion of a discipline throughout of the course. Ideally, it should be offered longitudinally, enabling a comprehensive approach and symptom management, promoting broad emotional and therapeutic skills in general care at all stages of life. The most highlighted skills for students are communication and management of symptoms and pain in the domains of communication and person-centered approach; end-of-life decision skills; PC principles and practices; philosophy and role of PC and hospice; control of pain and other symptoms.[26]

Of the three studies that directly addressed the development of skills, all highlighted the importance of basic concepts of PC, symptom management, communication skills and bioethics.[27-29] The research by Dias et al.,[29] in which a skills matrix for the geriatrician, also brought prerequisites of skills that precede residency (acquired during medical school).[29] Caldas et al.[27] based their study on a documentary analysis of the literature, with presentation to eight professionals from different areas with specialization in PC, while Quintilhano et al.[28] carried out a descriptive research, voted on by panelists from different areas, with space for action in PC (Chart 1).

DISCUSSION

The DCN for undergraduate Medicine courses in 2014 identify characteristics required of doctors in training that are in line with the guidelines for the practice of PC, such as: promoting relief from pain and other unpleasant symptoms; consider death as a normal life process, integrate psychological and spiritual aspects in patient care; offer a support system that allows the patient to live as actively as possible until the moment of death; offer a support system to help family members during illness and when facing grief; and offer a multidisciplinary approach to focus on the needs of patients and their relatives.[30]

Despite this, in the curricula of medicine courses, citations about death and the end-of-life process are brief and superficial, without a clear mention of the need to include PC.[31] This scarcity is reflected in

Chart 1. Mapping of suggested skills for graduation in Medicine.

	Palliative care (PC): a proposal for graduation in Medicine[24]
Type of Study: 1. Documentary Analysis 2.Descritive/ Exploratory/ Qualitative Year: 2018	Suggested skills matrix: Basic principles of PC: - Understand and apply PC definitions, principles and indications - Know the geographic distribution of PC services in Brazil - Provide patient care in PC and develop a care plan - Understand, apply and judge the communication of bad news in PC - Understand and help operationalize the functioning of PC services Symptom management - Assess pain, use minimal pharmacological treatment and indicate appropriate non-pharmacological treatment - Assess dyspnea, cough, nausea, vomiting, constipation, diarrhea, depression and insomnia and propose appropriate treatment - Assess delirium, anxiety, fatigue and oral health and predict more comprehensive treatment - Understand and technically apply hypodermoclysis - Understand and apply whether or not to continue nutrition in PC - Understand and provide care in controlling the symptoms of major emergencies in CP - Infer the applicability of PC in different specialties (Geriatrics, Pediatrics, Oncology, Family and Community Medicine, Pulmonology, Cardiology, Gastroenterology, Rheumatology, Nephrology, Anesthesiology, Neurology, Hematology and other medical specialties) and forward cases appropriately Team work - Judge and conceive in the future the dynamics of interprofessional relationships in your day-to-day work - Understand and participate in teamwork, emphasizing their role in total suffering Ethics - Estimate the importance of Brazilian law in the historical process of PC consolidation - Differentiate concepts in bioethics, contrasting the various practical situations that exist - Use advance directives in the patient's reality Care in the last moments of life - Guide the patient's last 48 hours of life and provide care in the last moments of life - Understand the definition of palliative sedation and palliative extubation, as well as when to use them - Detect and develop knowledge about the anticipatory grief of the patient, family and team - Evaluate the perspective of terminality in different religions, developed through clinical practice

Continue...

Chart 1. Continuation.

Definition of PC skills in the training of a general practioner[25]	
Type of Study: Descriptive/ Exploratory/ Qualitative; Quantitative Year: 2020	Suggested skills matrrix: Knowledge: - Know the concept of PC - Know the PC indication criteria - Know about PC in primary care - Know the doctor's attitude towards the death of their patient - Know the concept of total pain - Know the concept of terminal illness - Know the basic aspects home care - Understand the relationship between bioethics and PC - Know about the pharmacology and clinical use of opioids in PC - Mouth care, halitosis and oral infections - Know about nutrition in PC - Know how to refer to hospitalization when necessary - Recognize psychological, social and spiritual aspects in the PC approach with patient and their family member - Identification of pathological grief Skills: - Exercise empathy - Act with patience in PC - Work in a multidisciplinary/interdisciplinary team - Have a general practitioner view - Apply evidence-based medicine - Take the clinical history of the patient with a terminal illness - Control pain and other common symptoms - Coordinate secondary care with the health care network - Show availability to work in PC - Master urgent situations in terminal cancer patients - Prescribe blood products - Carry out the medical evolution of patients with terminal illnesses - Make progress on pain using scales - Communicate appropriately, including breaking bad news
26. Palliative medicine skills matrix for geriatrician[26]	
Type of Study Year: 2018	Suggested skills matrix expected for graduation: 1. Gathers and synthesizes essential and accurate information to define each patient's clinical problem(s) 2. Knows the definition and principles of PC 3. Understands that PC must be offered to patients at different stages of the potentially irreversible serious illness from diagnosis to the end of life 4. Adequately evaluates prevalent physical symptoms, with knowledge of pharmacology for appropriate use of medications, considering pharmacokinetics, pharmacodynamics, dosage and drug interactions 5. Exhibits integrity and ethical behavior in professional conduct 6. Knows strategies for adequate communication 7. Properly structures medical records, detailing evolution, care planning and adopted conduct 8. Develops appropriate interpersonal communication skills: displays empathetic and compassionate behavior; presents adequate verbal and non-verbal language. 9. Understands the need for PC team consultation and requests it when necessary 10. Recognizes grief as a process and as a possibility of becoming ill 11. Knows the basics of hypodermoclysis

the findings in recent literature. years in the country, in which there is a low presence of the topic in the pedagogical projects of medical school courses.[7]

The gaps in PC teaching in Brazil appear in the lack of adherence to teaching the topic and the need to improve its method and the number of hours available in the courses. Among the country's Medicine courses, 14% present the theme officially identified in their curricular matrices and, of these, only 12 are in the module format, with a workload of over 120 hours and a methodology with a theoretical and practical approach. In other institutions where the topic is covered, the median workload is 46.9 hours and teaching is predominantly theoretical.[26]

The weakness in the approach to PC teaching at undergraduate level is possibly reflected in the practice of medical professionals who work in PHC, even those with specific training for this, such as family and community doctors with medical residency in the area. A survey carried out with family doctors nationwide in 2019, even with the limitations imposed on this type of study, found that 92% of them did not have PC as a subject during their undergraduate studies. Thus, despite having specific training in Family and Community Medicine — MFC (residency and/or specialist title), they reported very low use of validated tools for PC management, as well as communication approaches related to PC with patients and their relatives.[32]

This weakness, previously detected by SBMFC, culminated in the insertion, in 2015, of a topic dedicated to PC in the competency-based curriculum (CBC), to guide the training of family doctors in residency programs.[33] In the aforementioned section of the document, there is a record of one skill expected as a prerequisite and 11 related to the essential level, referring to the minimum learning expected at the end of the residency. There is no record of desirable and advanced level skills in the PC section. Even though the inclusion of the topic in the CBC was fundamental, the skills designed still prove to be insufficient for the needs of PHC and the principles of PC. They are still weak, considering the guidelines of recent inductive policies in the country; and, above all, below the potential of the MFC specialty.[34,35] Furthermore, when we consider that less than 20% of professionals working in PHC in the SUS are family doctors with specialized training, this weakness becomes even more worrisome, since there are no formal training processes in PC for most general practitioners in the context of Brazilian PHC.

Other challenges for the implementation of teaching are the lack of prioritization, among other demands, and the shortage of qualified teachers.26 Whether due to lack of knowledge or the lack of clinical PC services, if there is no interest from the institution, it is unlikely that there will be investments for this discipline.[7] It is difficult for students to transpose the concepts covered in class into practice, as shown in one of the works on pain and PC.[14] Furthermore, part of the strangeness regarding the discipline comes from the students' mental suffering when exposed to patients with advanced diseases, who, in practice, should be helped by experienced teachers. Successive contacts with these patients are considered opportunities for learning and preventing burnout in future doctors. The development of emotional, relational skills that can include aspects of spirituality and resilience in compassionate care improves students' performance and confidence, as it boosts the effectiveness of communication and collaborative and interdisciplinary work.[26]

The results on PC teaching appear to be incipient, not only due to its low inclusion in the curricula, but also due to the non-standardization of these inclusions. Prioritizing the inclusion of PC teaching in undergraduate courses is an urgent and extremely important movement to guarantee good practices, allowing the development of assertive and humanized attitudes and decisions, both by students and medical professionals.[22] The perceived teaching weakness in medical school courses is particularly worrying in the PHC scenario in the country, where the majority of professionals still have generalist training and will possibly face difficulties with the growing demand for PC at this level of health.[29,32]

CONCLUSIONS

Both the attributes of PHC, especially longitudinality and comprehensiveness, and the skills desired for MFC are aligned with the skills necessary for the practice of PC in the health system. Despite this, the role of the MFC and the general practitioner in PC still appears to be incipient and limited within the scope of PHC, according to studies discussed in this work. One of the causes for this overview is the scarcity of PC teaching and practice during medical training. Although the Competence Curriculum for Family Doctors has the merit of formally addressing the topic in its structural matrix, the competencies defined as desirable do not meet the needs of practice nor do they consider the weaknesses in the prerequisites designed as a basis for the acquisition of skills in the area during resident training. Even more serious is knowing the overview of other general practitioners who work in PHC, who, in addition to the weakness in PC training resulting from the lack of approach at graduation, lack permanent training and education oth the attributes of PHC, especially longitudinality and comprehensiveness, and the skills desired for MFC are aligned with the competencies necessary for the practice of PC in the health system. Despite this, the role of the MFC and the general practitioner in PC still appears to be incipient and limited within the scope of PHC, according to studies discussed in this work. One of the causes for this overview is the scarcity of PC teaching and practice during medical training. Although the Competence Curriculum for Family Doctors has the merit of formally addressing the topic in its structural matrix, the skills defined as desirable do not meet the needs of practice nor do they consider the weaknesses in the prerequisites designed as a basis for the acquisition of skills in the area during resident training. Even more serious is knowing the overvieew of other general practitioners who work in PHC, who, in addition to the weakness in PC training resulting from the lack of approach at graduation, lack permanent training and education in service in the area.

Considering the overview of PC found in the country, as well as the recent guiding policies coming from the Ministry of Health, it is recommended that, while the approach to the topic is not formally foreseen in the curricular guidelines of Medicine courses, in-service training in area is intensified, in order to expand and qualify the care of people throughout their life cycles and in their terminalityin service in the area.

Considering the overview of PC found in the country, as well as the recent guiding policies coming from the Ministry of Health, it is recommended that, while the approach to the topic is not formally foreseen in the curricular guidelines of Medicine courses, in-service training in area is intensified, in order to expand and qualify the care of people throughout their life cycles and in their terminality.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

LGG: Conceptualization, Data curation, Formal analysis, Investigation, Writing – original draft, Writing – review & editing. IPM: Conceptualization, Formal analysis, Investigation, Writing – original draft, Writing – review & editing. DFG: Conceptualization, Investigation, Methodology, Project administration, Supervision, Validation, Writing – review & editing.

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