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THE ESSENTIAL ROLE OF MEDICAL PSYCHOLOGY IN THE MEDICINE UNDERGRADUATE CURRICULUM: A BRAZILIAN PERSPECTIVE

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ABSTRACT

Medical psychology purposes to study the psychological aspects of the student, the physician, the relationship between them, the family, and the institutional context of these relationships. The objective of this manuscript was to present the importance of medical psychology in the undergraduate course of medicine reporting the process of humanisation, the perception of anxieties and depression, empathy and a good understanding between doctor and patient. A systematic review of the literature and the deductive method was performed, which, through analysis and study of articles, inferred the importance of medical psychology in the medical course, selecting 18 articles for analysis. The formation of the humanised professional consists of countless factors; not only his theoretical knowledge, but also his observation, his practice, and his mental health will make him a better professional. Medical psychology has its importance in the personal life of the doctor and the doctor in training, in addition to building a service where humanisation and empathy are prioritized, creating a doctor-patient relationship necessary for the current times.

KEYWORDS: Medical Psychology, Doctor-Patient Relationship, Humanisation, Medicine Undergraduate.

INTRODUCTION

From the second half of the 20th century, the doctor-patient relationship has been addressed through different methods, with emphasis on the research conducted by Balint and Jaspers in Brazil, according to a study published by Alves *et al.*[1] Both methods seek medical humanisation and the relationship between doctor and patient, making this professional look at the person who seeks help and, from that point, thinks of possibilities for their care. It is worth noting that this relationship has been studied in the psychosomatic area, with relevant teaching activities and health practices, highlighting the importance of medical psychology as a discipline.

In 1995, the First National Meeting of Medical Psychology Teachers in Brazil took place, to conceptualize and delimit the field of this discipline, discussing about issues on how to teach medical psychology. Thus, two more meetings took place, contributing three important themes: the constitution of the subject, the doctor-patient relationship and the psychosomatic conception. In 2004, the IV National Meeting took place in Goiânia, where the Goiânia Charter was produced.[2] The Goiânia Charter, which portrayed that the discipline of medical psychology was dedicated to the subjective study of medical practice, including the doctor-patient relationship, support for students and teams, psychosocial aspects of the health-disease process and work with families and the community. After this declaration, the Curricular Guidelines for the teaching of Medical Psychology in Brazil were announced, being updated in 2014, delimiting what should or should not be taught, unifying the objectives and thematic contents that will be developed in undergraduate and medical schools in Brazil.[2]

Medical psychology aims to study the psychological aspects of the student, the physician, the relationship between them, the family, and the institutional context itself of these relationships, as conceptualized by Muniz and Chazan.[3] Given the several conflicting situations experienced by the students, such as pain, illness and death, situations that may lead to the development of anxiety and even depression. Medical psychology promotes behavioural changes and, thus, satisfactory responses are expected in the students' learning, reaching the objectives proposed in the subject of the medical course. According to Salgado *et al.*[4], the study of this discipline, in addition to helping the student in his personal life, aims to lead him in his profession, providing a more humanised view of the doctor to his patient and not only of the disease itself.

This research aims to analyse the importance of medical psychology in the medicine undergraduate curriculum reporting the process of humanisation, the perception of anxieties and depression, empathy and a good rapport between doctor and patient, thus allowing a better understanding of their respective ways of acting and thinking.

METHOD

The objective of this manuscript is to analyse the role the discipline of medical psychology in the undergraduate medicine curriculum. A systematic review of the literature and the deductive method was used, which through analysis and study of articles to infer the importance of this discipline. In the assortment of the bibliography, 30 articles were analysed and 18 were selected, between the years 2004 and 2020, in addition to secondary sources, such as textbooks, ordinances from the Ministry of Education and the Ministry of Health.

The articles were selected from journals and platforms listed in the Qualis Capes qualifying index. In addition, the first selection was carried out with analyses of the titles of each article and the reading of the abstracts, remaining only those closest to the proposal of this work; subsequently, the criteria listed above were used, filtering and selecting the 18 articles that made up the bibliography of this work.

The selected articles were extracted from the *Scielo* and Google Academic platforms, in addition to the Brazilian Journal of Medical Education, Brazilian Journal of Psychiatry and Journal of Psychosomatic Research, with the markers "medical psychology", "doctor-patient relationship", "medicine", "humanisation" and "importance".

DEVELOPMENT

In 2014, the Curricular Guidelines for the Medicine Undergraduate Course were updated, published in the Official Journal of the Union, in its Resolution No. 3 of 20 July 2014, which addresses, in its articles, the importance of medical psychology in the medical course. In articles 3, 5, 7, 12, 23, and 27, themes that include the humanistic formation of the student are addressed, always ensuring a humanised care, as provided in art. 3: "the undergraduate in medicine will have general, humanistic, critical, reflective, and ethical training"; art. 5: "integrity and humanisation of care through medical practice ... based on humanistic and ethical principles"; art. 12: "information and clarification of the need for clarification of the importance of medical psychology in the medical course". Art. 12: "information and clarification of the established hypotheses, in an ethical and humanised way"; Art. 23: "reflexive capacity and ethical, psychological and humanistic understanding of the doctor-person under care relationship"; Art. 27: "to include ethical and humanistic dimensions, developing in the student attitudes and values-oriented to multicultural active citizenship and human rights".[5]

Medical psychology as part of the curriculum is undoubtedly significant for the doctor-patient relationship (DPR)[6], having as the main objective of the study the human relationships in the medical context[3]; moreover, for Anfrísico Castelo Branco, described in his Manual of Medical Psychology, signs that the object of medical psychology is the DPR and the objective is to prepare the doctor psychologically to understand the sick person.[2] However, it is worth mentioning the relevance of medical psychology for the medical student, future doctor, based on two growing phenomena: depression and suicide. It is estimated that about 15 to 25% of students suffer from depressive and anxiety disorders during college, most of these being medical students. In addition, it is reported that, after accidents, suicide would be the second leading cause of death among these students[7] and, according to Kamski *et al.*[8], the ratio of suicides among physicians compared to the general population reaches 5:1 and 3:1.

According to Cavestro and Rocha[7], among the causes of depression and suicide, two prevailed among the studies: the high load of information at the beginning of the course and insecurity as to the medical career at the end. Furthermore, according to research carried out at Oxford University, substance abuse - such as alcohol - was indicated as an important cause for suicide and addiction may have a great relationship with the medical career[9]. It is also worth noting that data can be inaccurate regarding symptoms of depression and anxiety (often students have symptoms but are not diagnosed with the disorder[7] and suicidal ideation, which may go unnoticed among relatives and friends.[8]

According to Jeammet *et al.*[10], medical psychology considers in the medical relationship the role of everything that is of the order of the psyche, that is, everything that concerns the mental functioning of the patient and the doctor and all those who are involved in the caring function. For Abram Eksterman[11], medical psychology has been defined as the systematic study of the doctor-patient relationship.

Thus, it is observed that medical education, throughout graduation, should aim to show the student the biopsychosocial view of the disease. The doctor-patient relationship constitutes the basis for medical practice; thus, the importance of medical psychology is evident as a key role in teaching effective and satisfactory doctor-patient communication.[12]

The doctor-patient relationship began in Hippocratic medicine, with the objective of human beneficence, with a view of the whole person and not only the pathology. This relationship is formed by psychosocial processes[13], such as, for example, the transference and countertransference - discovered and studied by the psychoanalyst Freud, bringing an understanding to medical practice and the relationship with their patients.

Transference is the patient's relationship with the doctor. Specifically, it is the feelings of a past relationship or person that are transferred to current situations or the relationship with the doctor. There are two types, negative and positive. The negative are bad feelings, like hate, anger, resentment and sadness; on the other hand, the positive are good feelings, love, respect and trust. Also, in countertransference, the opposite of transference occurs, having a relationship between the doctor and patient. More deeply, these are the emotional responses of the doctor to the manifestations of the patient, which depend on the life history of the doctor. The attentive observation of the doctor, as much of the transferential manifestations of the patient as of his countertransferential reactions, will be of great help in the growth of both participants of this relationship, in daily care and also in professional life.[2] In short, the doctor-patient relationship is a very complete process, difficult to build. This relationship has its great importance in clinical practice, originating from the moment the patient arrives for care, analyzing the patient as a whole, not only analyzing what led him to an appointment, but his life story, his rights and wishes.[14] A good relationship between doctor and patient will never end, surpassing the walls of an office or hospital, involving the processes of humanisation and empathy.

In a doctor-patient relationship, it is necessary, above all, to have humanised care, through ethical principles and health management policies, being addressed in medical psychology. According to the National Policy for Humanisation (Humaniza SUS), created to improve healthcare services and the doctor-patient relationship, humanisation is defined as: "valuing users, workers and managers in the health production process. Valuing the subjects is to provide opportunities for greater autonomy, the expansion of their ability to transform the reality in which they live, through shared responsibility, the creation of solidarity bonds, collective participation in the processes of management and health production".[15]

Thus, recognizing the need for the humanisation of health care is still a large process. There is resistance from health professionals because it requires a change in their culturally constructed behaviour. Therefore, it is necessary and challenging that HEIs (Higher Education Institutions) include in their curricula and guide the training of physicians in humanised education, stimulating appreciation, integrity, and health promotion, in addition to seeing the patient as a person and not as a disease.[16] Therefore, the physician, when in contact with the patient's suffering, may create, through his/her own psychological defense mechanism, a distancing of the feeling towards the suffering of the patient. Therefore, to humanize is to make the physician get closer to this patient, providing quality care.[17] Moreover, another important factor for the doctor-patient relationship is empathy, included in humanised care. The doctor should be able to put himself in the patient's place, observing what happens in his body, but also in his life, and try to understand, from this analysis, what the complaints and reports mean to the patient.[5] For Barros *et al.*[18], the definition of empathy is compound by three settings:

1. Behavioural: explicitly conveys the acknowledgement that one has been understood, also without judgement, giving the other person the true feeling of being understood.
2. Affective: it is indicated by the perception of feelings of compassion and trustworthy concern for the person's well-being.
3. Cognitive: is associated with the effectiveness of recognising and taking into consideration, without judgement, the understanding and feelings of others.

In humanised care, empathy should occur in two phases. The first phase is understanding, listening and attention sincerely and helpfully; the second is communicating what has been understood and understood. In turn, in a consultation, the demonstration of understanding by the doctor and the feeling of being understood (and accepted), generates empathy. The patient's insight in having his feelings taken into account implies positively building safety and trust, making him feel comfortable with the situation being exported, thus causing a humanised care.[18]

RESULTS

At the time of the research, 30 studies were identified, involving subjects related to depressive disorders in medical students and, also, the importance of medical psychology in the medical course schedule, where 18 were part of the inclusion in the construction of this review. And of these, only 4 studies were considered for the elaboration of the results of this article, because only these manuscripts were considered as quantified researches. The synthesis of the studies selected and reviewed in the present study is presented in table 1.

Table 1: Authors selected for the preparation of results and discussion.

Authors/year	Objective	Conclusion
Cavestro *et al.*(2006)	To show the prevalence of depressive disorders among medical students.	10.5% of the students interviewed had depressive disorders, while at other universities it ranged between 8% and 17% of the students interviewed.
Clark and Zeldow (1988) apud Cavestro *et al.*(2006)	Interviewing medical students on five different occasions with structured interviews.	12% of the students showed depressive symptoms during any period of college; the highest percentage was at the end of the second year, 25%.

Silva *et al.*(2015)	To present humanisation in medical education, from the analysis of the curriculum of two medical courses.	In one university, 10.55% of the medical course syllabus includes subjects with some humanistic content; in another university, this percentage falls to 6.58%.
Costa *et al.*(2009)	Interview personal trajectory, doctor-patient relationship (DPR) and empathy.	DPR was one of the most valued findings of the research; empathy is something to be imparted rather than taught and learned.

DISCUSSION

In the Cavestro *et al.*[7] research, it was estimated that 10.5% of students had depressive disorders, which is at the lower limit of the prevalence rates of depressive disorders among medical students.

In longitudinal studies, Cavestro *et al.*[7], in which he cited the studies of Clark and Zeldow, interviewed medical students on five different occasions with structured interviews. The results showed that 12% of the students had depressive symptoms in any university period, with the highest percentage at the end of the second year, 25%.

According to the analysis of the study by Silva *et al.*[19], knowing the reality of the place where one is inserted is essential for the humanised professional, because in this way, he/she can maintain a dialogue with his/her patients, guiding and outlining better strategies for solutions to certain diseases or problems that arise with the treatment. The patient needs to be understood as a biopsychosocial being, vulnerable to the environment and to his mind that goes through several alterations throughout life; and for the physician to understand all this condition, it is necessary to overthrow all mechanical thinking that is based on diagnosis, treatment to reestablish the "normality" of the human-machine reaching its social well-being.

The research released by Costa *et al.*[13] is based on 19 interviews, with 13 male and 6 female lecturers, where the interview was based on personal trajectory, doctor-patient relationship (DPR) and empathy. Empathy is more related to feelings than cognition. The DPR was one of the most valued findings of the research, being one of the most important in the proposed work, as this is a necessary, effective means of obtaining results integrated into good professional technique allied to empathy, with the use of non-verbal tools to assist DPR. Costa *et al.*[13] emphasise that empathy is something to be transmitted in the training of new physicians and not taught and learnt. Curricular reforms that positively reinforce the training of skills aimed at consolidating practices and experiences of a DPR may have empathy as a foundation.

In the research published Silva *et al.*[19], humanisation in medical education was discussed based on the analysis of the curriculum of two medical courses. In both universities, the Universidade Estadual de Londrina - UEL (table 2) and the Universidade Federal do Paraná - UFPR (table 3), of the six-year undergraduate courses, only up to the fourth year were subjects with some humanistic foundation. Then it was analyzed that only 10.55% of the curriculum of the medical course of the UEL is of subjects with some humanistic content, while in the UFPR this percentage drops to 6.58%, totalling a drop of 3.97%. Another relevant point of this analysis is the moment in which these subjects are inserted in the curricular grid, and that in the last two years of college, these subjects are practically extinct; this being the prime period of contact with patients and family members and the best time to put into practice the theoretical learning, thus no subject helps and encourages the student to reflect on the patient and the way he feels and not even on the effect of contact with suffering on health professionals seen only in the first years of the medicine undergraduate course.

Table 2: State University of Londrina (UEL).

Subjects of Humanistic Contents	Hourly rate
1ST YEAR	
Clinical skills and attitudes I	132
Practices of Interaction Teaching, Services and Community I	102
Other Subjects	970
2ND YEAR	
Clinical skills and attitudes II	136
Practices of Interaction Teaching, Services and Community II	132
Other Subjects	944
3RD YEAR	
Clinical skills and attitudes III	132
Practices of Interaction Teaching, Services and Community III	132
Other Subjects	918
4TH YEAR	
Clinical skills and attitudes IV	132
Practices of Interaction Teaching, Services and Community IV	132
Other Subjects	892
5TH YEAR	
Technical disciplines	2391
6TH YEAR	
Technical disciplines	2613

Table 3: Federal University of Paraná (UFPR).

Subjects of Humanistic Contents	Hourly rate
1ST PERIOD	
Technical disciplines	670
2ND PRIORITY	
Medical Propaedeutics I	90
Technical disciplines	510
3RD PRIORITY	
Medical Propaedeutics II	80
Health and Society	60
Technical disciplines	490
4TH PERIOD	
Medical Propaedeutics III	120
Technical disciplines	426
5TH PERIOD	
Technical disciplines	580
6TH PERIOD	
Integral Health Care I	100
Technical disciplines	480
7TH PERIOD	
Integral Health Care II	160
Technical disciplines	500
8TH PERIOD	
Philosophical bases of medical practice	20
Technical disciplines	480
9TH PERIOD	
Technical disciplines	200
10TH PERIOD	
Technical disciplines	1760
11TH PERIOD	
Technical disciplines	1760
12TH PERIOD	
Technical disciplines	1080

The formation of the humanised professional consists of numerous factors, not only their theoretical knowledge but also their observation and practice will make them better professionals. Humanisation must be associated with care and practice throughout the course.

CONCLUSIONS

It is well known that medical psychology goes far beyond the academic sphere of teaching and learning. Medical psychology plays an important role in the personal life of the doctor and the doctor in training, as well as in building a service where humanisation and empathy are prioritised, creating a doctor-patient relationship which is necessary for current times.

Zygmut Bauman[20], in his book "Liquid Modernity", discusses human relationships in which society lives, being a superficial relationship, with fragility in the bond between people, and the relationship is increasingly cold, especially in the doctor-patient aspect. Thus, medical psychology aims to return to this solid modernity, consolidating relationships, making them more human and empathetic, besides having the concern of the human being in its general context, whether doctor or patient.

Finally, the discipline of medical psychology should have a greater workload in the curricula of medical courses, being experienced in all years of medical training, being a place for the student to express the feelings experienced during the practices, being provided psychological care and, in addition, to be transmitted, for learning, a good and humane doctor-patient relationship.

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