Anjos da Guarda *(Guardian Angels):* Medical Teaching Tool

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Abstract: Conventional medicine combines biotechnoscientific knowledge with care. However, medical schools have placed greater emphasis on scientific knowledge to the detriment of the doctor-patient relationship. **Objectives:** This report aims to describe the immersion experience lived by four sixth-term medical students during the months of February and March 2020. **Method:** Such immersion took place in a teaching project named *Anjos da Guarda*, which is used as a medical education tool at the Gaffrée e Guinle University Hospital of the Federal University of the State of Rio de Janeiro (HUGG-UNIRIO). **Results:** The *Anjos da Guarda* Project develops medical professionalism, empathy and the fundamentals of medicine centered on the patient as part of the care process, without underestimating the importance of biotechnoscientific knowledge and clinical reasoning. **Conclusion:** The experience enabled gains in learning for students, in addition to contributing to the health system and benefiting the patients involved.

➤ **Keywords:** Medical education. Professional competence. Doctor-patient relationship.

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Introduction

The National Curriculum Guidelines (CNE, 2001) require training that includes a generalist and reflective professional with humanistic capacity (BASTOS, 2005). Amid the pressure to be a good medical student (WACKERBARTH, 2020), academics lose sight of the essence of the profession in order to meet curricular requirements. Some factors, such as the extensive theoretical workload and the stress when preparing for the residency test, lead the student to exhaustion and lack of interest (GALÁN *et al.*, 2011). Semiology is the discipline that brings the moment when there is the first contact between the student and the patient. However, the student, immersed by the excessive demands of the curriculum, does not recognize that, before them, there is a person who does not necessarily follow a pattern described in books.

The term "physician", from the Greek, means to be involved in clinical work, focusing mainly on the relief of human suffering (WACKERBARTH, 2020). Based on the *Anjos da Guarda* Project (PAG) (BASTOS, 2013), a new project with the same name has been implemented at the Federal University of the State of Rio de Janeiro (UNIRIO), at its Gaffrée e Guinle University Hospital (HUGG), in order to bring students closer to the medical experience, awaken empathy, genuine interest in the responsibility of the profession and teach medical professionalism (SWICK, 2000; SCHLEIFER; VANNATA, 2019). The project is based on a teaching process, which goes beyond the traditional idea of lectures and seeks the mutual construction of knowledge through participatory lessons that transcend the walls of a classroom (ANASTASIOU; ALVES, 2015).

The clinical method, a professional tool used in the *Anjos da Guarda* Project and developed by Professor Ricardo Rocha Bastos, consisted of a few steps: reception, interview, physical examination, list of problems, complementary tests, proposals for action and follow-up (BASTOS, 2013).). This approach allows the collection of differentiated personal data that has interpersonal communication skills, paying attention to non-verbal language and listening with genuine interest, which generate respect and trust between patients and doctors. As a result, a better doctor-patient relationship can reduce the lack of communication and lack of supervision that lead to medical error (ZULMAN, 2020), can contribute to adherence and encouragement to treatment (ANDERSON, 2007; ZULMAN, 2020).), can

facilitate the description of the clinical condition and reduce the professional's chance of Burnout (MIEDANY, 2019; SCHLEIFER; VANNATTA, 2019, p. 89).

The clinical method deals with the doctor-patient relationship. And at all stages of this relationship, not only filling out a form (anamnesis) but also building a partnership with the patient, so that there is a bond of trust between them (BASTOS, 2013). A true relationship between the person to be cared for and their caregivers must be established. In this relationship, professor and student, although not directly responsible for the conduct, serve as a link between the person who suffers and the professional responsible for the case.

This experience report describes PAG at the School of Medicine and Surgery of Rio de Janeiro (EMC), an institution linked to UNIRIO, offering students the opportunity to develop the clinical method and medical reasoning. The project is founded on practice based on scientific literature and establishing bonds in order to offer the best medical practice to those we care for (COULEHAN; BLOCK, 2006).

Anjos da Guarda Project's Original Methodology

One of the main objectives of the project is to achieve medical professionalism, which involves a constant intellectual pursuit, as biomedical knowledge grows exponentially. Therefore, physicians must capture information and use it to make clinical decisions, constantly updating themselves (SWICK, 2000). In this sense, the project strengthens academic training by developing essential skills for good medical practice. We learn, with each patient, the different health conditions, because each patient has comorbidities, family, physiological and social histories of the most diverse.

Originally, the project is made up of pairs, with one fourth-term student (pupil) and another ninth-term student (angel) working together. The student of the later term ends up sharing knowledge with the pupil, in a fruitful coexistence that the medical school precinds in its activities. Angel and pupil welcome, interview, examine and follow up the patient until the day of discharge, not having official responsibility for the care. At the beginning of the action, the angel takes the lead, closely watched by the pupil. With time and acquisition of experience, the angel allows the pupil to take act, supported by the angel (BASTOS, 2005).

Every patient accompanied by the students is presented, at bedside, to the preceptor and to the other pairs. This is the first contact of the preceptor and the other students with the patient, which marks the meaning of presenting the case

and the possibility of teaching clinical reasoning, at the moment it is developed by the preceptor. The presentation must be objective and use technical language, offering useful information to build the diagnosis and care process, in addition to making known who that person is, the terrain in which the disease is installed. This presentation must contain the preliminary identification of the patient, the reason for hospitalization, the path taken in the health system until reaching the current hospitalization, the disease, other important data from the interview, physical examination, complementary exams and information about the person.

The project proposes the interview to be carried out based on recent literature on the topic, such as the books *O Método Clínico* (The Clinical Method), by Ricardo Bastos (BASTOS, 2013), and The Medical Interview: mastering skills for clinical practice, by Coulehan and Block (COULEHAN; BLOCK, 2006). Initially, the setting and reception must be done so that the patient feels comfortable even to refuse the interview, and the student is prepared for the activity that requires great intellectual effort. The student's first words should be: "Hello, I'm (present their first name), a medical student, I'm part of this ward team and I need to talk to you. Can we talk now?" The setting begins with the registration of the student's name on the lab coat (MENAHEM; SHVARTZMAN, 1998; TIANG, 2017), with external preparation being a fundamental element in helping to identify the person and the health team. In a ward, the best time for the interview must be chosen. Ideally, the patient should be sitting on the bed and the student who is going to interview them should also find a chair to sit next to, if possible. Thus, the message that there is a willingness to listen will be understood by the patient as a form of welcoming (PLATT *et al.*, 2001; ANDERSON, 2007; RUSH, 2019).

Subsequently, the preliminary identification is made. The essential points to start a professional conversation are identified, using textual questions: "What is your full name? How old are you? When is your birthday? What is your full address? What's your cell phone number and your e-mail? Have you always lived in this city?" The questions must present genuine interest in what is being informed, collecting data that allow identifying and finding the patient when necessary. Typical census taker questions, such as: "Full name? Birth date? Address?" must be avoided. Such questions limit the patient's speech, and put the interviewer in control of the dialogue (REALINI, 1995). This way, the bond between those involved in the interview increases and an environment conducive to the doctor-patient connection is created (BASTOS, 2013).

The interview itself opens with the first propitiatory question: "When did all this start, did you go to the doctor for the first time, why?" And so, the patient tells the reason for seeking care initially, describing signs and symptoms and, often, their path in the system. The intention of this question is to understand how the disease started, to build an approach for most initial signs and symptoms of the most prevalent pathologies in our environment (BASTOS, 2013; BOISSY *et al.*, 2016; GILLIGAN, 2020).

The patient's response to the first propitiatory question is called free speech. At this moment, it is important to listen carefully, without interrupting (REALINI, 1995). Active listening is carried out, seeking to understand the story objectively (PLATT *et al.*, 2001; COULEHAN; BLOCK, 2006; ANDERSON, 2007). It is recommended to write down some information telegraphically, using terms or expressions that the patient has spoken. This is not the time to interpret, in scientific terms, the words heard. It is important to write down what you could not memorize. A lot of information that appears here is about the disease, and also about the path taken in the system. It is essential to distinguish the information from these two topics (grievance and path in the system), so as not to confuse them.

Carrying on with the interview, guided questioning should be done, with queries to better understand the most important parts of free speech. You go through all the terms written down or memorized, essential to get to know the problem, the path in the system and the person. It is time to use precision, always showing genuine interest in understanding the details of the notes and what was memorized, seeking to translate this information, transforming it into technical-scientific terms (WÜNDRICH *et al.*, 2017; FEINSTEIN 1997; YEDIDIA *et al.*, 2017; FEINSTEIN 1997; YEDIDIA *et al.* al., 2003; COULEHAN; BLOCK, 2006).

The next step is the general questioning. The students previously inform the patient that they will be asked questions to get to know them better. These questions should be asked the same way for all people interviewed for the first time. Interrogations that seek to certify the past pathological history; hospitalizations and operations; about the physiological history; the weight; immunization and some aspects of social history. More important than remembering all these items, is choosing the best questions to ask, demonstrating empathy and acceptance (YEDIDIA *et al.*, 2003; BUCKER *et al.*, 2018).

After that, the interview continues with the second propitiatory question: "Who else lives in your house?" Through this question, we seek to enter into the person's intimacy, identifying who are those who live with them, what is their health status and how their life is in general. The interest in the story told is what will make all the difference in the interview, especially since this stage is a moment of sincerity, respect and empathy. This is where we get to know the person best and allow their feelings to be expressed in gestures and words. Active listening is needed. It also takes the opportunity to learn more about the family history. If you haven't talked about parents and siblings, you might ask: "Tell me a little about your parents? Do you have sibblings?" With these questions, the objective is to know a little more about the person and look for common diseases in the family (GUTTMACHER, 2004; COULEHAN; BLOCK, 2006; BASTOS, 2013; WUNDRICH *et al.*, 2017).

Finally, the third propitiatory question is asked: "Is there anything else we haven't talked about that you would like to say now?" In this way, the patient is given the opportunity to close the interview. It is, once again, a demonstration of genuine interest. It is often at this point that very important information is obtained.

After the presentation, the students and the professor go to another place to discuss the cases. Initially, they talk about the difficulties found in applying the clinical method and raise ways to better deal with them. Afterwards, each pair presents the vignette, that is, a small technical report that exposes the essential data for the formulation of medical reasoning. It includes data from the interview, physical examination and complementary exams. From this, the professor helps preparing a study agenda, by asking the question: "What should I learn so that, in the future, I can better serve a person with a similar presentation?". In this way, students improve their clinical reasoning and learn to search for suggested literature (BUTTI; REGO, 2011). The project also advocates patient follow-up after discharge. This is accomplished with the visit of the pair to the Basic Health Unit or by a home visit (BASTOS, 2005).

Experience Report

The first contact with the *Anjos da Guarda* Project took place in 2019. At that time, it was not possible to implement the it according to the initial proposal due to some difficulties reported later on. Seeking to experience the project to its fullest, in

February and March 2020, four students of the sixth term of medicine and an EMC preceptor at HUGG made an immersion, following the original steps of the project.

Based on the original model, it was decided to take the immersion in this teaching methodology in a way adapted to the students' reality. In pairs, one of the members interviewed a patient while the other observed. In this case, because the students were all in the same term, there was a rotation in the role of pupil and angel. The presentations took place in the days following the interviews. After the presentation, in an amphitheater, there was a discussion on the vignette with the suggested bibliography.

One of the main challenges for the medical student and the doctor is to gather information given and shape the story in partnership with the patient, taking into account the impact of the disease on physical and psychological health (MIEDANY, 2019). However, traditional medicine leads us to believe that the way forward is to shorten the consultation time and speed up the interview, disregarding the creation of a bond with the patient and the diagnostic power of a well-conducted interview (CROMBIE, 1963). Other times, they are satisfied with information collected by another professional, ignoring the quality of this collection, which can harm the care (RUSH, 2019). This behavior can leave hidden countless aspects and perceptions that could be observed with the medical interview (COULEHAN, 2006; WILLIAMS, 2001), associated with a professional conversation between the caregiver and the person to be cared for.

Following the interview, the bedside presentation, which takes place before the preceptor, offers the student a practical learning experience. The clinical professor observes how the student behaves with the patient, their companions and the health team. Students also learn by observing the preceptor's attitude towards the same people and, later, still receive guidance regarding bedside performance for improvement (DICHI; DICHI, 2006). This contact with the patient and the clinical professor, at the same time, is a unique moment capable of teaching about ethics, professionalism and improving clinical skills (GOLDBERG *et al.*, 2016; GONZALO *et al.*, 2008).

The presentation, at the bedside, is arranged between the students and the patient in advance, at the end of the physical examination, so that they do not feel exposed. In this conversation, the academics clarify that they will tell their story to colleagues and to the professor, using medical terms that they may not understand

and that, after the presentation, they will return to the bed to talk and answer any questions that may have arisen (LEHMANN *et al.* ., 1997). It is a moment when the patient realizes the meticulous attention they are receiving and the opening of future space to ask questions and reassure themselves (LOPES, 1998). Thus, they understand more about their health condition and, also, their considerations about the treatment are heard. Thus, the person's autonomy is stimulated, contributing to better results (PLATT *et al.*, 2001; PINHEIRO; MATTOS, 2006).

In another place, the ward's amphitheater, there is a discussion about the aspects of the presentation. The clinical professor makes observations regarding the students' presentation, the construction of the clinical vignette, the attitude towards the patient, their companions and health team; clinical reasoning based on the interpretation of the interview, physical examination and complementary exams; in addition to guidance regarding the reference to be sought from the topic presented by the patient during the interview and filtered by the professor. This way, the project inverts the outdated logic of medical education, in which theory is given first and then practice, prioritizing the chronology of a real medical encounter.

It is important to emphasize that the project does not only impact the student's formation, but also the functioning of the health service. Using the technique of medical interview and the relevant physical examination, with proficiency, information is obtained that is not included in the medical record and was not collected by any other professional. Thus, the student works by contributing to the doctors who are directly responsible for the care of patients, transmitting information to the team that had not been considered before and providing a better conduct.

One of the difficulties encountered in the practice of actions was the implementation of the project for a larger group of students. This is because, when the project was carried out with about 30 students, in 2019, there was a single clinical professor to accompany them. Many students, therefore, were unable to experience the bedside presentation. The lack of more professors involved with the project may have several reasons, one of which is reported to be the professors' discomfort when they are not previously aware of the case presented (BASTOS, 2005).

In this edition of the project, no home visits were possible. The possibility of visiting or, at least, making telephone contact with the units of origin in future editions was then raised. To strengthen this contact, it is suggested to write a counter-referral to the primary care unit responsible for the patient, as a project activity

(FITTIPALDI NETO *et al.*, 2018). As a result, communication between teaching hospitals and primary care would be strengthened, also encouraging permanent education (JESUS *et al.*, 2011).

Another difficulty encountered during the second half of 2019, when, due to the extensive workload of theoretical classes, there was some incompatibility of schedules between preceptor and students, so that meetings were not possible. The presentations were then sent to the professor through a messaging application and the professor would correct them, leaving comments. However, the unique experience of presenting the case at the bedside and promoting an enriching and personal debate with the professor was lost.

Conclusions

The experience of the *Anjos da Guarda* Project was a possibility of finding a methodology that goes beyond traditional medical teaching. The members of this immersion were sensitized to the creation of a bond with the patient, with special attention to communication and teamwork. In addition to directing the study by recommending reliable literature to enrich clinical reasoning, the professor is perceived as the one who has the function of cutting incongruities, presenting important valences of a good doctor. The doctor-patient relationship and the presence of a professor-clinician at the bedside presentations generated fruitful results of learning and professionalism.

The practice of this teaching model was also able to bring benefits to the health service and patients. The service professionals showed acceptance towards the attitude of the students participating in the project. In addition, the empathy, respect and genuine interest developed contributed to the biopsychosocial improvement of the person being cared for and to the improvement in collecting essential information from history and physical exams that had not been found before. It is understood that the creation of a bond, the person-centered interview, the appropriate physical examination and the request for relevant complementary exams are fundamental for good medical practice, in addition to the necessary constant search for biotechnoscientific knowledge.

It was decisively found that clinical reasoning, medical professionalism, empathy and medicine centered on the person as the protagonist of care, were the basis of the

experience. The experience of the project was enriching and its continuity tends to contribute to an integral medical education. The *Anjos da Guarda* Project proved to be an excellent medical teaching tool, also benefiting the various actors of a university hospital, culminating in comprehensive and high quality care for the patient. [1]

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Note

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Resumo

Anjos da Guarda: ferramenta para o ensino médico

A verdadeira medicina combina conhecimento biotecnocientífico ao cuidado. No entanto, as escolas médicas têm dado maior ênfase ao conhecimento científico em detrimento da relação médico-paciente. **Objetivos:** Este relato tem como objetivo descrever a experiência de imersão vivida por quatro estudantes de medicina do sexto período nos meses de fevereiro e março de 2020. **Método:** Tal imersão deu-se em um projeto de ensino denominado Anjos da Guarda, o qual é usado como ferramenta de educação médica no Hospital Universitário Gaffrée e Guinle da Universidade Federal do Estado do Rio de Janeiro (HUGG-UNIRIO). **Resultados:** O Projeto Anjos da Guarda desenvolve o profissionalismo médico, a empatia e os fundamentos da medicina centrados na pessoa do paciente como parte do processo de cuidado, sem menosprezar a importância do conhecimento biotecnocientífico e do raciocínio clínico. **Conclusão:** A experiência possibilitou ganhos em aprendizado para os estudantes, além de contribuir com o sistema de saúde e de beneficiar os pacientes envolvidos.

➤ **Palavras-chave:** Educação médica. Competência profissional. Relação médico-paciente.