RBEM Revista Brasileira de Educação Médica

ORIGINAL ARTICLE

DOI: https://doi.org/10.1590/1981-5271v49.4-2025-0030.ING

Moral sensitivity and the ethical formation of Medical students

Sensibilidade moral e a formação ética do estudante de Medicina

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ABSTRACT

Introduction: Medical education must integrate technical, ethical, and humanistic training, promoting critical socialization. The hidden curriculum has been shown to negatively influence the ethical formation of medical students.

Objective: This study investigates the influence of the hidden curriculum on the ethical training and development of moral sensitivity in medical students.

Method: A qualitative approach was employed through 15 interviews with students in the final stages of their internship. The interviews were analyzed using thematic analysis methodology, focusing on categories related to ethics education and practice.

Results: Three main categories were identified: the impact of ethics teaching, organizational ethical climate, and teachers' professional attitude. Students perceived ethics teaching as theoretical and disconnected from clinical practice, with non-interactive methodologies. The organizational climate was characterized by competition, hostility, and conflict. The preceptors' attitude reflected continuous criticism and devaluation of the students, negatively affecting the development of moral sensitivity.

Conclusion: The study reveals that the hidden curriculum significantly interferes with ethical formation, highlighting the need for greater integration between theory and practice, as well as the adoption of methodologies that encourage ethical reflection during medical training.

Keywords: Ethical Training; Hidden Curriculum; Moral Sensitivity; Medical Education.

RESUMO

Introdução: *A educação médica deve integrar capacitação técnica, ética e humanística, promovendo uma socialização crítica. O currículo oculto tem se mostrado um fator que influencia negativamente a formação ética dos alunos de Medicina.*

Objetivo: *Este estudo investigou a influência do currículo oculto na formação ética e no desenvolvimento da sensibilidade moral dos estudantes de Medicina.*

Método: *Utilizou-se uma abordagem qualitativa com entrevista coletiva realizadas com estudantes em regime de internato, no final do curso. As entrevistas foram analisadas por meio de uma metodologia de análise temática, observando categorias relacionadas ao ensino e à prática da ética.*

Resultado: *Foram identificadas três categorias principais: impacto do ensino da ética, clima ético-organizacional e atitude profissional docente. Os estudantes consideraram o ensino da ética teórico e desconectado da prática clínica, com metodologias não interativas. O clima organizacional era caracterizado por competição, hostilidade e conflitos. Já a atitude dos médicos preceptores refletia críticas contínuas e desvalorização dos estudantes, influenciando negativamente o desenvolvimento da sensibilidade moral.*

Conclusão: *O estudo revela que o currículo oculto interfere significativamente na formação ética, evidenciando a necessidade de uma maior integração entre teoria e prática, além de metodologias que estimulem a reflexão ética durante a formação médica.*

Palavras-chave: *Formação Ética; Currículo Oculto; Sensibilidade Moral; Educação Médica.*

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Chief Editor: Rosiane Viana Zuza Diniz
Associate Editor: Andrea Tenorio

Received on 02/12/25; Accepted on 07/08/25.

Evaluated by double blind review process.

DOI: https://doi.org/10.1590/1981-5271v49.4-2025-0030.ING

INTRODUCTION

The training of medical students in Brazil is directly related to social demands and technological advances, requiring undergraduate medical courses to adopt practices that promote both technical and ethical and humanistic development. The 2014 National Curriculum Guidelines (DNC, *Diretrizes Nacionais Curriculares*) highlight the importance of training physicians with a critical and reflective view, trained to act with social responsibility and guided by solid ethical principles, aiming to respond to the needs of the population. In other words, the medical student needs, in addition to technical training, the integration of an ethical posture in the face of the clinical and contemporary challenges of Medicine[1].

Moral sensitivity involves the ability to identify and respond appropriately to ethical and humanistic issues that arise in interactions with patients, colleagues, and society[2]. Moral sensitivity is crucial for future doctors to be able to meet the needs of their patients in a humanized way, understanding the complexity of interpersonal relationships and the importance of ethical and empathetic practice.

However, this formative process is strongly influenced by the hidden curriculum – a set of informal and implicit teachings that students internalize throughout their academic trajectory. Although it is not present in the formal curriculum, the hidden curriculum can exert a decisive influence on the way students develop their values and professional behaviors [3].

Frequently, the hidden curriculum transmits norms, behaviors and attitudes that may be in disagreement with the explicitly taught ethical principles, leading students to adopt a dehumanizing and technicist posture, that is, it can lead to the loss of moral sensitivity of medical students throughout their training [4].

The central problem of this study lies precisely in the analysis of this influence of the hidden curriculum on the development of medical students' moral sensitivity. Although the formal curriculum of medical schools seeks to integrate disciplines of medical ethics, bioethics, and the humanities, the hidden curriculum, transmitted through the attitudes and behaviors of teachers and preceptors, often prioritizes technical efficiency and hierarchy to the detriment of empathy and ethical sensitivity[5].

Thus, it is questioned how the hidden curriculum impacts the ethical training and the development of medical students' moral sensitivity in an internship regime. At this stage, many students report that the pressure to conform to institutional norms and hierarchies, as well as the exposure to unethical behavior on the part of their preceptors, end up undermining empathy and reinforcing a more technical and detached view of Medicine[6].

Thus, the relevance of this study lies in its ability to offer a contribution to the field of medical education by exploring the gaps and challenges that compromise the ethical development of future physicians. Understanding how the hidden curriculum interferes in the ethical formation and moral sensitivity of medical students in internship is essential to create pedagogical strategies that promote a more humanized medical practice that is aligned with contemporary ethical principles[2]. Thus, investigating the relationship between the hidden curriculum and ethical training can contribute to the discussion of teaching methodologies that promote greater student engagement with the ethical values of the profession, mitigating the negative effects of the hidden curriculum and strengthening the development of empathy and ethics in future doctors[7].

Medical education in Brazil needs to be based on training that integrates technical-scientific knowledge with moral sensitivity and ethical responsibility. Thus, it will be possible to train health professionals who not only master medical techniques, but who are able to act with compassion, respect, and commitment to the well-being of patients and society [8].

Therefore, this study aims to analyze how the hidden curriculum interferes in the moral sensitivity and ethical formation of medical students in medical internship[9]. Critical hermeneutics analyzes language, interpreting observed meanings and revealing power dynamics in social and cultural contexts, as well as rejecting models that claim to present an absolute truth, recognizing that human meaning can never be fully revealed[10].

METHOD

This study uses a qualitative approach, with an exploratory design, based on critical hermeneutics.

The study was conducted with medical students at the Mineiros University Center, located in Mineiros, Goiás state, whose political-pedagogical project focuses on active methodologies as a teaching model. In the first semester of 2022, the University Center had approximately 2,200 students enrolled in 15 undergraduate programs.

The target population consisted of medical students in the internship stage, that is, students attending the last two years of the undergraduate course. Fifteen students were selected according to the criterion of intentional sampling, which seeks participants who meet the specific objectives of the study. The choice was directed to students in an advanced formative stage, ensuring that their experiences in the internship were significant for the understanding of the analyzed phenomenon.

These periods were selected because it is a crucial moment in the practical application of ethical concepts,

since, in the internship, students face real clinical situations that demand a consolidated ethical and professional posture. The collective interview was guided by a script of guiding questions, addressing the teaching-learning experiences in the different spaces and activities during the internship, as well as their perceptions regarding the moral aspects of this process.

A total of 15 medical students were interviewed, 9 of whom were in the second year of internship and 6 in the first. The interviews took place in three periods, between February 2023 and September 2024, conducted by the researcher in one-hour sessions, with a pre-established script. The participants were asked about the impact of preceptors, advisors and the multiprofessional team on their ethical training, in addition to the effect of the disciplines of bioethics and ethics on the students' training. To ensure confidentiality, all interviewees signed a consent form and their identities were preserved by acronyms in the answer records. The interviews took place online via Teams, with audio recording for transcription.

The data were analyzed using thematic analysis, a flexible methodology as described by Braun and Clarke: "through its theoretical freedom, thematic analysis provides a flexible and useful research tool, capable of generating a rich and detailed set of data, which can be used for a variety of epistemologies and research questions"[11].

The process followed the six stages of the Braun and Clarke method[11]: detailed reading of the data, with the objective of reaching the content with depth and breadth; extraction of key elements, selecting aspects identified with the topics that stood out in the previous process; grouping into thematic categories, searching for topics and these were confronted with our theoretical framework and in our research question. For the refinement stage, the topics were reviewed after rereading the data set and the relationship of the topics with the data was verified. After verifying the data, whether they are in accordance with the research question (since the codes generated during the initial stages could be grouped according to the studied topics), markers with different colors were used to signal each topic and then their definition and denomination were carried out. For the last stage, the results were integrated into an analytical narrative, and the report was produced. It reconsiders the theoretical aspects related to the research work.

Therefore, three main thematic categories were identified, which reflect different aspects of the hidden curriculum and its implications on the moral sensitivity and ethical formation of students: "Impacts of the Teaching of Ethics", "Organizational Ethical Climate" and "The Attitude of the Professional as Faculty".

The study was approved by the UNISINOS Human Research Ethics Committee (CEP) – Opinion N. 5,595,034.

RESULTS AND DISCUSSION

The thematic analysis identified three main categories related to the impacts of the hidden curriculum on the ethical training and moral sensitivity of medical students: Impacts of the Teaching of Ethics, Organizational Ethical Climate and Attitude of the Teaching Professional. Each one addresses specific aspects that significantly influence the ethical formation of students.

Impacts of the Teaching of Ethics

The students of this institution, according to the PPC (Pedagogical Project of the Medicine Course), received ethics teachings in the first semester with the discipline Ethics of the Medical Student according to the Federal Council of Medicine, in the second semester, the discipline Ethnic-Racial Education Relationship, in the third semester the discipline Ethics and Citizenship and in the eighth semester, the discipline Medical Ethics. In parallel to these disciplines, the discipline Communication Skills was also offered in the second semester of the course, with the purpose of developing the practice of the doctor-patient relationship.

However, this category highlights flaws in the teaching of ethics in the socialization of medical students, evident during the clinical practice of the internship. Deficiencies in the learning methodology and in the content taught were pointed out, which did not prepare students to reflect and deal with moral conflicts in clinical practice.

The methodology used in the teaching of ethics was widely criticized by the students, who highlighted the lack of reflective and interactive practices as one of the biggest obstacles to ethical training. The reports pointed out that the methodological approach, centered on theoretical expositions and not connected to the reality of clinical medicine, compromised learning and generated disinterest.

One student reported: "The teacher only gave us theoretical texts to read, but we lacked something more interactive, such as real discussions or practical examples" (Tulip, 5th year).

One student pointed out that even when active methodologies were implemented, their flawed implementation hindered learning.

> *"The methodology was active, but they gave us the code of medical ethics for us to read the articles and then they gave very complex cases, which were more related to the law, with terms that we were not aware of. So, in end, we were very dispersed there, we were not interested" (Magnolia, 5th year).*

The inadequate implementation of the methodology in teaching reveals the teachers' pedagogical unpreparedness,

bringing theoretical-clinical activities out of context, not arousing the student's interest. One student stated that "the classes seemed bureaucratic, as if they were just to comply with the schedule. Something was missing that really caught our attention" (Jasmine, 6th year).

These reports highlight the prioritization of technical-scientific disciplines to the detriment of humanistic ones, reflecting an implicit hierarchy that devalues ethical and humanistic aspects of medical practice. This undervaluation directly impacts the integral formation of students, limiting their development of reflective capacity and ethical understanding due to unstructured and teacher/preceptor-dependent ethical teaching. One student highlights that "we learned more about the applicability of medical ethics by accompanying the teachers in the internship practice" (Rose, 6th year).

Another student highlighted the methodological superficiality of the teaching of ethics and the difficulty in hospital routine:

> *"We lacked bringing cases for us to discuss, to see how each situation can be different. I think this would help to better deal with what we find in the hospital" (Sunflower, 6th year).*

Another student highlighted as a consequence of this gap the difficulty in developing essential skills, such as communication, decision-making and professional interaction. They showed a lot of insecurity in the face of ethical dilemmas in the clinical environment, "without practical examples, we are insecure. Now, at the internship, we have to deal with serious situations and it seems that we are not prepared" (Amaryllis, 6th year).

The content taught in the ethics discipline proved to be dissonant with the common hospital practice. This incoherence did not stimulate reflection, rational and cognitive criticism of ethical situations that occur in the hospital environment. As one student exemplifies:

> *"They were not such specific cases, it was not so targeted in our practice. So, that's why I think it was more difficult for us to be interested, because the teacher would sometimes use a text that was very much like that, a little too philosophical, too subjective. I think it had to be more practical, even a clinical case, for example, a case of a patient, what happened, if there was a lawsuit, I think it would be more useful that way, more interesting" (Hortense, 5th year).*

Another student pointed out that the content taught did not meet the requirements of the hospital routine, reinforcing the need for modification:

> *"For me, the issue of medical ethics, we didn't have anything real related. There was a subject of general ethics, which we saw in the prep school or at school. But studying really, all the precepts and concepts of ethics itself, in everyday life, we didn't have that" (Daisy, 6th year).*

Another student pointed out that during the teaching of ethics, they had a legal viewpoint, with content for making correct decisions according to the principles and norms of the professional code of ethics and that there was no application of bioethical principles and no emotional learning of values and attitudes.

> *"The content presented by him was from a medical view of medical law; It was a lawyer's view of medical law. So, for us, it was little aggregated, it didn't add up to that much" (Carnation, 6th year).*

The students pointed to the absence of a clear alignment between the objectives of the formal curriculum and the practical needs of students for survival during medical internship:

> *"This issue of medical ethics was a wasted subject, I learned little and it is an important subject and we have no idea what needs to be done" (Rose, 6th year).*

The National Curriculum Guidelines for Medicine courses[1] recommend active pedagogical methodologies, aiming to develop students' ethical sensitivity. Teaching should start from the analysis of clinical-ethical problems, promoting reflection and deliberation on moral conflicts in medical practice. To achieve this goal, it is necessary to integrate theory and practice through curricula based on real problems of the medical internship, which facilitates the application of ethical concepts and the development of technical and cognitive skills and values such as tolerance and compassion[4].

This requires a robust integration between theory and practice, as a way to consolidate the security, autonomy and sensitivity of future professionals [12]. And for this to be achieved, it is necessary that educators be technically competent and ethically apt to practice [13].

Teacher unpreparedness is one of the central causes of this problem, evidencing the need for clearer ethical guidelines and better didactic and pedagogical training. The teaching of bioethics, in turn, should not be limited to the normative application of ethical principles, but should include hermeneutic-practical skills, allowing students to interpret moral problems in specific contexts [14].

It is important to distinguish the ethical action of the physician, which respects autonomy and benefits the patient, from moral conflicts, where there is uncertainty about the correct action. A classic example is the patient's refusal to receive treatment, requiring the physician to deliberate on the best course of action [15].

DOI: https://doi.org/10.1590/1981-5271v49.4-2025-0030.ING

Medical ethics points to the normal duties of the practice of medicine as set forth in the code. Clinical ethics or clinical bioethics, on the contrary, deals with the moral conflicts that this exercise raises, the answer to which is not simply in the code[16]. To resolve these controversial issues, it is necessary to learn deliberation methodologies that help to ethically analyze the conflicting values and what is the most appropriate path of solution. This difference points to the necessary distinction in the medical curriculum between medical ethics, which is the study of the professional duties of the code, and clinical bioethics, which helps in learning deliberation methodologies to resolve moral conflicts in clinical practice [15,17].

In this sense, ethical learning is not limited to normative understanding, but involves an active process of reflection on the social and moral implications of the decisions made. This process requires deliberation, including the ability to understand and value otherness and promoting reflections on the impact of one's own actions on others [4].

The distinction between the formal curriculum and the hidden curriculum is a crucial aspect in the analysis of ethical training. The formal curriculum, defined by the curricular guidelines and explicit teaching objectives, is based on active methodologies, promoting the development of critical reasoning, the ability to deal with responsibilities and uncertainties, and communication and technical-scientific skills [4]. The data showed that the pedagogical practice does not always correspond to the official ideology and the environment of interactions often denies what is proposed as ethical. Therefore, the hidden curriculum, emerging from interpersonal interactions and cultural practices in the academic and clinical environment, often operates as a set of informal knowledge that profoundly impacts medical education [18,19].

This hidden curriculum, although not directly evaluated, plays an essential role in the socialization of students. However, it also highlights significant problems, such as the lack of pedagogical training of preceptors and teachers.

Semberoiz[12] points out that hidden socialization can negatively influence the students' performance, since these professionals often do not have the necessary training to deal with ethical challenges in the practical environment, demotivating students.

Organizational Ethical Climate

This category deals with the dynamics of power and relationship in the hospital environment, especially in the interactions of students with professionals who are not their preceptors, such as the interdisciplinary team and residents[20]. Competition and hierarchization affect the ethical climate, impacting professional socialization, moral sensitivity, and ethical development during internship and contradict the principles and guidelines of interprofessional education and collaborative work.

The relationship with the interdisciplinary team, consisting of several professionals, was marked by reports of competitiveness and lack of acceptance. This attitude hindered practical learning, generating a non-collaborative environment that impacted the safety and integration of students in the hospital. One student reported that "some professionals don't even say good morning. It seems that we are always getting in the way of their service" (Rose, 6th year).

Another highlighted the discomfort generated by the hostile environment, *"people don't feel like saying good morning. It's very bad. I felt extremely uncomfortable" (Violet, 5th year).*

The perception of devaluation and the lack of support from the team were also mentioned by the student as, *"sometimes the team speaks rudely and we feel disorganized. It is not a welcoming climate for those who are learning" (Daisy, 5th year).*

These communication and interaction difficulties generated a sense of exclusion in students, compromising the development of collaborative and ethical skills. Thus, the team's competitive posture was often seen as an obstacle to practical learning. One student commented: *"we have to always be walking on eggshells with the team. It seems that they are always ready to criticize us" (Tulip, 6th year).*

Concomitant with these reports, the preceptor's lack of preparation was evidenced regarding the lack of attitude to guide the student on how to overcome these challenges. One student commented: "*in a patient service I was asked to leave very rudely and I said I would not leave... The teacher was on the side, he was just watching... Later the nurse said a lot of things to me.*" (Azalea, 6th year)

This lack of support made it difficult to build a respectful and empathetic relationship between students and professionals, increasing the barriers to effective learning. Relations with resident physicians were described as hierarchical and marked by conflicts. Students often reported a sense of professional superiority, rather than collaboration, due to the domineering posture of some residents. As noted by one student: *"residents want to dominate everything and treat us as if we were competitors, not learning partners" (Jasmine, 6th year).*

This attitude contributed to the feeling of isolation and devaluation on the part of students, especially at times when support was essential for learning. One student mentioned that *"there are days when it seems that we shouldn't even be there. There is a lack of adequate guidance and even simple help" (Lilly, 6th year).*

The attitude of superiority of some residents was a highlighted barrier. One student commented, "*we did all the work and in the end we were not recognized, the resident only*

took credit for what we did" (Sunflower, 5th year). This hierarchical relationship disfavored socialization and collaborative learning, strengthening the feeling of insecurity and demotivation among students. In the context of the medical internship, where students interact directly with patients and multidisciplinary teams, communication skills become indispensable. Therefore, the problematization of the contexts of practice is essential for the acquisition of ethical skills and moral sensitivity. In this sense, the lack of a structured reflective environment can lead to the perpetuation of dehumanized practices, making it difficult to develop a solid ethical attitude[5].

Interprofessional Education (IPE) and collaborative work are fundamental to improve the quality of health care, promoting the integration of different professionals and collaboration to meet the needs of users. The principles of interprofessional education include learning about, with, and among each other to better understand each other's roles and responsibilities; sharing knowledge among professionals is essential for the construction of a more comprehensive care; recognize the roles of each professional, identifying the importance of their role within the team and how they contribute to patient care; develop communication and teamwork skills – as clear, effective and respectful communication is fundamental for teamwork, items are essential for producing more effective and safe care for decision-making[21,22].

The Guidelines for the implementation of interprofessional education should be incorporated into the training of health professionals from the undergraduate level, promoting the development of relevant skills and competencies. Interprofessional practice should be carried out in different care settings, such as hospitals, health centers, and other health services. Interprofessional education should involve professionals from different areas, such as doctors, nurses, physiotherapists, psychologists, social workers, among others, in addition to always keeping in mind the well-being and needs of the user, seeking a more comprehensive and humanized care[21,22].

The teamwork environment plays an important pedagogical role, promoting a service committed to the democratization of relationships, reflecting quality, embracement and humanization[16]. This requires an organizational culture that favors an ethical climate, transparency, and reflection.

This importance of the organizational climate points to the need for an ethical framework [8] at the level of practical interactions that confronts the manifestations of the hidden curriculum present in attitudes of competitiveness and hierarchization that deny professionalism [17]. If the professional training of students is more related to the hidden informal messages disseminated in the environment than to the objectives of the formal curriculum, then the ethical framework that inspires and motivates the relationships of the academic context of Medicine has a fundamental role and needs to be made aware and assumed so that it can be the focus of the medical socialization of students.

The ethical framework will be decisive for the formation of the moral character of students through the construction of a subjectivity that responds to the moral demands of the medical profession [12]. A focus on the environment of practices is relevant for the creation of professional ethical competencies.

The study revealed that students face situations of hierarchy and competition, generating insecurity, anxiety and moral suffering. These dynamics affect moral sensitivity, compromising learning and the development of interpersonal and ethical skills. The hospital-centered model reinforces an individualistic and technicist clinical practice, focused on productivity and technical efficiency[24,12].

Teaching in clinical settings often presents implicit barriers, such as bullying and disrespectful attitudes, as part of the hidden curriculum, which prevent students from feeling part of the hospital context. As a consequence, students hide doubts or feelings, reinforcing a cycle of isolation and incomplete learning. In turn, the hierarchization of teaching affects access to knowledge, harming the training of future doctors and hindering the internalization of ethical and humanistic values [19.] This analysis reveals the importance of rethinking pedagogical and organizational practices in hospital contexts, promoting a culture of embracement, respect and mutual appreciation, capable of integrating students in a more constructive and ethical way into the clinical environment[19]. That is, to insistently seek the balance between biomedical training and the human formation of students [12].

Thus, the medical student will learn the competence to deliberate and decide with technical intelligence and empathetic humanization, in situations of uncertainty typical of clinical experience, requiring scientific knowledge and self-knowledge, with an additional ability to anticipate the consequences and the courage to act [26].

The attitude of the professional (preceptor/teacher) as faculty

This category explores the influence of the attitudes of preceptors and teachers on the ethical and moral development of medical students, especially during internship. The direct relationship between preceptors/teachers and students plays a crucial role in ethical formation, reflecting both in pedagogical practices and in the professional attitude demonstrated in the clinical environment.

The preceptor's function is characterized by the exercise of direct supervision of the practical activities carried out by medical students in the health services where the internship is developed, exercised by a professional linked to the training or executing institution. They are professionals responsible for teaching-service integration, whose duties include planning, stimulating, directing, monitoring and evaluating the learning process of medical students.

However, the preceptors' pedagogical practice was highlighted as a negative challenge for the students' ethical learning. Authoritarian comments, lack of motivation and lack of acceptance on the part of preceptors contributed to the students' insecurity in practical situations. One student shared that, *"the teacher didn't answer our questions and that left us completely lost." (Orchid, 6th year).*

Another student reported the feeling of devaluation caused by the disrespectful attitude of a preceptor, *"the teacher called us idiots and didn't help at all. It's just demotivating." (Carnation, 6th year).*

These demotivating attitudes, associated with a rigid hierarchy, inhibited open dialogue and embracement, negatively impacting the students' ethical formation and self-confidence. The absence of constructive feedback hindered the development of humanistic skills and discouraged the expression of doubts and emotions, hindering their comprehensive formation.

Therefore, many students mentioned that the pedagogical attitude of some preceptors who prioritized technical aspects to the detriment of the ethical discussion of the clinic was demotivating, reinforcing a limited view of the role of the health professional in medical practice.

As a result, these students often replicated observed behaviors, out of fear and dread, without proper reflection on the ethical impact of their actions. One participant highlighted, "*the preceptors made us feel constantly threatened, always afraid of making mistakes and being criticized" (Lilly, 6th year).*

This combination of the lack of pedagogical sensitivity with demotivating attitudes points to the need for a liberating and critical education as a basis for arousing moral sensitivity in medical students. This requires preceptors who value dialogue and empathy, creating a welcoming and reflective environment with educational practices that value dialogue and ethical reflection, providing a solid ethical education aligned with the demands of professional practice [12].

Another aspect pointed out by the results is the professional attitude of the preceptor, because, consciously or unconsciously, they transmit to the students, norms and values through their attitudes, which can undermine their idealized formal messages of what it means to be ethical. Every word spoken, every act performed or omitted, every joke made, every silence maintained or every disappointment manifested in an intra-hospital environment, has a greater influence on the learner than what is taught as an ethical stance [27].

Hidden socialization motivates, in a negative way, the students' performance, mainly because there is a non-professional behavior transmitted by the educators. Added to this, is the lack of preparation and inadequacy in the psychological aspects to which they are exposed due to the contradictory and harmful messages of the hidden curriculum, making them feel unmotivated and induced to lack ethical coherence [12].

Hence, the need to understand the hidden curriculum as an essential element in medical education, which can both enhance and hinder the ethical development of students. For this to happen, it is necessary to have a critical curricular work that includes a reflection on the influences of power, tradition and politics on the curricular structure, on who organizes the curriculum, how biomedicine configures and fixes the fundamental categories of the curriculum[28].

Within the hidden curriculum, hostilities to students can also occur, such as verbal, institutional, physical, sexual and racial harassment[7]. These events are often silenced by students, creating a shell to defend themselves, dulling empathy and compassion, leading to negligent and abusive behavior against the people in their care [12].

The challenge of the educator of the medical student is to be vigilant in their pedagogical practice, always remembering their main attributions, whose discourse and practice must go together based on respect, acceptance and coexistence with differences, allowing the student to awaken to moral sensitivity towards the other and critical reflection in the face of situations [3, 18].

The teacher of Medicine must have the ability to teach deliberation to recognize the existence of a moral problem and sensitivity to distinguish, in a clinical situation, the issues that deserve moral considerations, promoting moral reasoning with arguments in view of a decision that is morally justifiable, enhancing the moral motivation to carry it out and placing the values inherent to the profession above personal or institutional interests [18].

To resolve ethical conflicts arising from clinical cases, the principles of medical ethics present in the code are not enough, it is necessary to know bioethical deliberation methodologies that help to ethically resolve moral conflicts without falling into the fallacy of transforming problems that require various paths of solution into dilemmas that oppose two antagonistic solutions [29].

CONCLUSION

The ethical training of the professional socialization of medical students is an essential component for the construction of moral sensitivity. However, the research data demonstrated that the teaching of ethics is theoretical and abstract, disconnected from clinical practice. In this sense, learning methodologies are not active, because they do not start from problems to be solved.

Therefore, it is essential that the teaching of ethics be more connected to clinical practice, with the implementation of methodologies that value activities that promote the development of skills such as leadership, empathy, and communication. Another crucial highlighted point is the impact of the hidden curriculum, which, although not formally explained, exerts a decisive influence on the ethical formation of students.

The dependence on preceptors and teachers without the appropriate pedagogical training reinforces behaviors that are not always aligned with ethical values. This organizational gap requires medical education institutions to rethink their educational strategies, incorporating pedagogical practices that promote critical reflection and the practical application of ethical principles. Thus, curricular restructuring and pedagogical training of teachers are fundamental steps so that ethical training is no longer perceived as decontextualized and becomes an effective tool in the construction of ethical, sensitive professionals prepared to deal with the challenges of modern medicine.

Although we were careful in analyzing the data, this study has some limitations because it is interpretative and can influence the veracity and accuracy of the information. One limitation is that interviews were conducted for this study. These do not offer anonymity and this can influence participants' willingness to share information honestly. Another limitation is the fact that it was carried out with a small sample, and this may make it difficult to generalize the results to the population as a whole.

This study may also be limited by the presence of biases, such as the influence of the interviewer on the interviewees. Therefore, for this item, the researcher was required to have a precise, attentive and careful attitude with the participants, in order to ensure the validity of the results.

Based on these results, it would be interesting to research the impact of the influence of the hidden curriculum on ethical education in medical students.

AUTHORS' CONTRIBUTIONS

Jose Roque Junges provided guidance, coordination, correction; Rafaela Schaefer contributed with guidance. Melissa Carvalho Martins de Abreu contributed with the idea, performance, description, research

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

SOURCES OF FUNDING

The authors declare no sources of funding.

DATA AVAILABILITY STATEMENT

Research data are available in the body of the document.

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