A barefoot physician? A community physician? Imaginaries about the first physicians of the Universidad Tecnológica of Pereira.

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Abstract

The approach to imaginaries represents an additional way of understanding the meaning of the processes that led to the origin of institutions and their cultural products. This article presents the main results of the analysis of the social imaginaries present during the process of creation of the School of Medicine of the Universidad Tecnológica de Pereira, in relation to the design of the physician's profile. Under the methodological guidelines of the grounded theory, an audiovisual documentary body was analyzed, consisting of fourteen interviews to academic and social managers, teachers and first graduates about their participation in the described period and the circumstances surrounding the design of the profile and the arguments of acceptance or rejection. From the initial analysis, the semantic clouds of the profile, acceptance, rejection, and practice scenarios were constructed. The emerging categories that defined the profile were: "community medicine", "comprehensive training" and "practice scenarios". These imaginaries are related to the formation of an integral physician, committed to the community and aware of his or her role in social transformation. In contrast, other imag-

inaries related the conception of the initial profile to a low quality physician, destined to the first levels of care and without a solid scientific training.

The study of a social reality is nourished not only by the historical conditions of its production, but also by the analysis and understanding of the imaginaries that also make its origin possible. The study of the profile of the doctor of the Universidad Tecnológica de Pereira, under this perspective, constitutes an important advance in the construction of meaning.

Keywords: Community Medicine; Primary Health Care; Comprehensive Health Care; physicians

Resumen

El abordaje de los imaginarios representa una forma adicional de comprensión del significado de los procesos que dieron origen a las instituciones y a sus productos culturales. Este artículo presenta los resultados principales del análisis de los imaginarios sociales presentes durante el proceso de creación de la Facultad de Medicina de la Universidad Tecnológica de Pereira, en relación con el diseño del perfil del médico. Bajo los lineamientos metodológicos de la teoría fundamentada, se analizó un cuerpo documental audiovisual constituido por catorce entrevistas a gestores académicos y sociales, docentes y primeros egresados acerca de su participación en el periodo descrito y las circunstancias alrededor del diseño del perfil y los argumentos de aceptación o rechazo. Del análisis inicial se construyeron las nubes semánticas del perfil, aceptación, rechazo y la de escenarios de práctica. Las categorías emergentes que definieron el perfil fueron: "medicina comunitaria", "formación integral" y "escenarios de práctica". Estos imaginarios se relacionan con la formación de un médico integral, comprometido con la comunidad y consciente de su rol en la transformación social. En contraste, otros imaginarios relacionaron la concepción del perfil inicial, con un médico de baja calidad, destinado a los primeros niveles de atención y sin una sólida formación científica.

El estudio de una realidad social se nutre no solo de las condiciones históricas de su producción, sino del análisis y comprensión de los imaginarios que también posibilitan su origen. El estudio del perfil del médico de la Universidad Tecnológica de Pereira, bajo esta mirada, constituye un importante avance en la construcción de sentido.

Palabras clave: Medicina Comunitaria; Atención Primaria en Salud; Cuidado Integral de la Salud; médicos.

Introduction

The importance of records for the preservation of memory is a relatively recent development. It is probably due to the recognition of the importance of treasuring, safeguarding, and disseminating the historical heritage of institutions, collective memory and testimony of human experience. For universities, the use of their archives guarantees the tracing and transfer of knowledge, for this reason the Faculty of Health Sciences of the Universidad Tecnológica de Pereira (UTP), has undertaken in recent years a recovery of its memory (1, 2), in an effort to provide teachers, students and the general public, an opportunity to explore the history of their programs and learn about the circumstances surrounding their creation, tools for their vision of the future.

One of the most interesting elements of academic programs is the conception of the profile. It is usually the result of extensive discussions among teachers, professionals and experts in education, to condense, in a paragraph of the program's educational project, the expected competencies and the distinctive character of the future professional. In the case of the School of Medicine, this "profile" was reflected in the first study plan as follows:

> ....to train medical professionals with a new nationalistic orientation, which not only assures them the necessary scientific preparation, but also enables them, through direct knowledge of the situation of their community, to help it in the correct approach and adequate solution of its problems, mainly in the area of health, and to direct them towards the exercise of an institutional and less private medical practice. (3)

The concept of social imaginary was created by Castoriadis (4) who argued that human relations depend to a great extent on the mental constructions that the individual has fabricated and has been fabricated. These constructions and meanings (figures, forms, images) are manifested in social-historical institutions. In addition, it will be necessary to recognize that, in this construction process, subjective and complex elements that can be the object of study also take part.

This research, the first of its kind in the institution, gives a novel twist to the traditional studies carried out so far and addresses the analysis of the local, national and international circumstances of health and medical education, which conditioned the imaginaries present during the discussion of the first profile of the UTP physician and that probably affected its design or the discourses of acceptance and rejection that produced its presentation

to the academic community and society of the time.

Materials and Methods

Historical qualitative research, under the guidelines of grounded theory (5) that identified the most relevant imaginaries present during the design of the first profile of the UTP physician. The heuristic and hermeneutic components were applied to the data collected from the transcriptions of a group of fourteen semi-structured interviews. The entire process is summarized as follows:

1. Planning: selection of a group of professionals (teachers, administrators, and graduates) recognized for the role they played or for their direct knowledge of the process of creation of the School of Medicine. The interviewers received training and carried out simulations prior to the beginning of the data collection. The interviewees, after accepting their consent, agreed to answer the questions freely, to explain their perspectives and to go deeper into the topics they considered relevant. All interviews were recorded.
2. Transcription: written reproduction of the informants' voices through software (Nvivo transcription). The content was checked against the audios to ensure their fidelity. The selected categories and emerging categories were identified from the textual units. Finally, a peer review of the coding was carried out in order to identify the existence of new codes not considered in the first recording.
3. Identification of categories: the selected categories were confronted with the knowledge accumulated in the bibliographic review, in order to complete and configure the meaning of the opinions. Simultaneously, a saturation matrix was elaborated to identify those common categories that were part of the daily world of the informants.
4. Analysis and interpretation: identification of axial categories. The triangulation of collation confronted the voices of the informants, those of the accumulated knowledge and those of the researchers on the concept of the medical profile.
5. Semantic clouds: for their construction we followed the methodology proposed by Fernández (6) and the cloud creation option of the NVivo software. A graphic visualization of the main words/concepts that configured each dimension was obtained. The size of the word was directly related to its frequency of occurrence in the discourse. The purification of the semantic clouds included the elimination of

direct references to the term, of linguistic elements without referential value, of verb forms of the verbs to be and to do, in addition to those verbs that denoted the opinionated nature of the response. Adjectives, adverbs of quantity and adverbs of time, among others, were also eliminated.

Results

Physician profile (Figure 1.).

The word community is the most frequent. So are a group of expressions that can be associated with the collective, such as social, people, world, and society, while terms such as hospitals, clinics, specialists, areas, departments are mentioned less frequently.

Figure 1. Semantic cloud on physician profile

Some related codes were the following:

S7-01:07:23: The community or communitarian approach in a medical program refers to the integral vision of the physician, who not only takes care of the sick and the institutionalized patient but is also concerned with collective activities.

S1-d2-03:50: There was the fashion of community medicine, because it was a medicine for the people, we had to serve the people and there was the model of social medicine oriented to the people who had money, it was a change for us, we had an orientation towards the people who did not have money and that caused some hilarity.

The word *health* is predominant when compared to the term disease and

the word *prevention* predominates over *curative*. In the center of the cloud, the concepts of vision and commitment stand out, shared with words such as *training*, *students*, *social and people*.

> *S13-20:01: Yes, when we intervened, when we went to different scenarios, to Purembará, to attend the indigenous people who were totally neglected, when we had, we went to the health centers, that the doctor was not regularly trained in the health centers and in the rural areas, we felt the importance of this approach that our faculty brought..., but we do not see the reality of the difficulties to have health in a rural area or in a depressed area, as there are many here and in all parts of the world. Those depressed areas that do not have drinking water, that do not have adequate waste disposal or that do not even have resources for food, such as the indigenous peoples themselves.*

This and other voices encountered seem to correspond to a perceived change in the concept of health and in the importance of meeting the health needs of the population. The opinions of the interviewees on events of the time, such as the Declaration of the Presidents of the Americas, signed in Punta del Este (1967) and the International Health Conference of Alma Ata (1978), stand out in this regard.

> *S8-00:00: We are talking about the 70's and in the 70's there was a great concern, I believe that not only at Latin American level, but also at world level, and it was the problem of the lack of coverage, the lack of coverage in the provision of health services. And that generated meetings in Latin America on what to do, because the countries argued that the provision of health services did not reach the total population and there were some very important meetings, such as in Punta del Este, but all this came to fruition in 1978 with the great meeting of the World Health Organization in Russia, in Alma Ata, and then health for all was discussed in the year 2000.*

Program acceptance.

The most frequent voices belong to the local (university, technological) and national environment, such as the Colombian Association of Medical Schools (ASCOFAME by its acronym in Spanish) and the Colombian Institute for the Promotion of Higher Education (ICFES by its acronym in Spanish). The words *community*, *communitarian*, and terms associated with the *commitment* of the actors *(success*, *balance*, *pride*, *leader)* or the moment of creation *(opportunity)* are repeated (Figure 2).

Figure 2. Semantic cloud on program acceptance.

Comprehensive physician training was one of the most frequently expressed concepts closely associated with community medicine.

> *S6-04:12: What is the university's own hallmark, we could point out that it was a comprehensive physician, with a solid background in community medicine.*
>
> *S7-01:07:23: The community or communitarian approach in a medical program refers to the integral vision of the physician, who not only takes care of the sick and the institutionalized patient but is also concerned with collective activities.*

According to the interviewees, the medical program, from its beginnings, included non-clinical (community) and primary care scenarios for the health practices of its students, which became a differentiating factor and a characteristic of the profile of the first graduates.

> *S13-20:01: That positioned us as physicians very much. That was the positive, shocking part when we started going out, which was very early. In the first semester we started to go out to recognize the areas that had no health care, to see the community in its habitat, not by coming to us, but by going to them.*

Rejection of the program

Like the cloud of acceptance, this cloud is dominated by the word *community*. Around it, there are expressions that refer to local *(university)* and national (ASCOFAME) institutions, accompanied by terms such as *problems*, *difficulties*, *difficult*. There are also concepts associated with practice sites

such as *clinics and hospitals*. In the external part, voices linked to the context of education *(training, curriculum, quality, training, study, competence, knowledge)* are found. Finally, on the periphery, there are words from the administrative and financial context *(money, coverage, costs, economic, execution, contributions)* (Figure 3).

Figure 3. Semantic cloud about program rejection.

The word ASCOFAME appears in the semantic clouds of acceptance and rejection. It could reflect a change of position with respect to the project and the proposed profile.

> *S9-00:30: When the project arrived with the radical opposition of ASCOFAME, they did not want the faculty, despite the fact that we had already changed our original concept of the faculty to that, let's call it that, of barefoot doctors, they continued to oppose it.*

The expression barefoot doctors was associated with others such as critics, communists, absurd, opposition, clearly opposed to words such as hospital, clinic, professors, meetings, associated with institutional practice scenarios and traditional forms of teaching.

> *S3-00:21Here they invented something that was going to be a school of community medicine. That was an invention that was invented, and the faculty started as a faculty of community medicine.*

S8-04:10: Some voices were raised thinking that what was being proposed at the Universidad Tecnológica was to officialize a kind of health promoter type of doctor..., the story was brought up that they were working with barefoot doctors in China in the East and so they were like community doctors, but with a low profile, low, low training.

Finally, the semantic clouds of profile, acceptance and rejection contain phrases related to training and practice settings (hospital, clinic, departments, sites, community). Some voices emphasize the benefits of this early exposure in training.

S1-d3-p7: People think that medicine is in the hospitals, but medicine is also in the streets, in the market place, we went and attended there; we took medicine to the people.

Discussion

The analysis of the semantic clouds and codes found identified three categories related to each other and closely related to the profile of the UTP physician: **community medicine, comprehensive training, and practice settings**. These dimensions correspond to the type of international proposals for medical care and training stated in the mid and late 1970s.

The creation of the medical program at UTP takes place in this context. In the seventies, globalization emerged from the peak of the scientific and technological revolution initiated after World War II. The Alma Ata conference (1978) represented the most important milestone in public health policies and marked the sector in the international arena. There, the goal of "Health for all" was established and Primary Health Care (PHC) was determined as a tool, a strategy that requires a comprehensive approach, more preventive than curative (7,8). The analysis of the interviews allows inferring that managers were familiar with these concepts and reflected them in the discussions and in the design of the physician profile.

Community Medicine.

The origin of the term Community Medicine is not known exactly (9). According to Bastidas (10), it emerged in the 1960s as a multi-institutional and multi-professional approach in the poorest populations of the United States. Fourteen years later, a meeting of the study group on Community Medicine was held in Rio de Janeiro to reflect on the scope of the concept in Latin America and the need to reorient the physician's work and the leading role of the population in health activities (11).

In academia, community medicine was incorporated into the curriculum of many medical programs as a way of responding to the challenges of the health services situation, which required new pedagogical models. Related concepts were also incorporated, such as PHC, Community Oriented Primary Care (hereinafter referred to as APOC by its acronym in Spanish), Public Health and Social Medicine, among others, which acquired great notoriety in the following years (12).

For some interviewees, community health as an integrating concept of human life includes the protection of life, human rights, and the environment (13). In addition to epidemiological, biological, social and economic aspects, community health has a political, anthropological and ecological meaning (14).

> *S8-00:00: There were people concerned about the need to talk about a physician with certain characteristics that I do not think were aimed at denying the importance that the physician had had, but rather at adding a series of characteristics that would make it possible to respond to this, to this commitment to health for all in the year 2000. And then we began to talk about community medicine and some people may have studied in depth the philosophy behind it.*

The social character of community medicine is underpinned by community participation and is based on PHC, with a holistic and humanistic approach, especially for the low-income population. Bastidas (10) affirms that the community approach seeks to train integral physicians, with broad training, who can act at all levels of care.

In contrast to the above, other opinions collected associated community medicine with a deficient training of the future UTP physician. The proposals for the integral improvement of health systems expressed by the World Health Organization (WHO), and made concrete at the Alma Ata meeting (15), empathized with similar strategies in different countries of the world, such as those of the Christian Medical Commission, the movement of barefoot doctors in communist China, Cuban doctors (16) and some leftist groups, among others (17). These visions of medical practice were criticized by some theoreticians as simplistic, second-class care, exclusive for the poor population, lacking scientific evidence (17) and aimed at underdeveloped countries (18).

It is possible that these positions were known to the academic and administrative authorities of the nascent UTP medical program. Hence the position of rejection that can be deduced from some of their opinions:

> *S10-02:52: …They said that what they are going to create is doctors like the idea of the barefoot doctors of communist China…. with doctors who were not the most scientific in the world, but who could go to solve specific problems of the population.*

The integral physician.

At the time of the creation of the medicine program, it was possible to identify two models of health care-training in Ibero-America (19). The impulse of new technologies in informatics in the 70s and 80s gave a glimpse of a model of care characterized by an emphasis on diagnosis and therapy, with the help of high technology. Simultaneously, another model coexisted, inspired by WHO guidelines and by movements such as "holistic medicine" in the United States, based on health promotion and the importance of disease prevention, in addition to consideration of the social and cultural aspects of health care (20).

The latter model was not without opposition for some of the interviewees:

> *S4-06:08: One of the psychiatrists, Dr. Gómez (former dean of this faculty and trained in the U.S.), said that these community medicine tricks, that this was from communist countries and not here, that there was no understanding of what community medicine was, when initially this was the focus that he had.*

Practice scenarios.

The scenarios for medical training have oscillated between a model whose common denominator is the accompaniment and learning alongside the sick and an extra-institutional one, which includes the healthy population. In this regard, Chavarriaga (21) affirms that in the 50s and 60s, the Universidad del Valle and Universidad de Antioquia created the Family Medicine programs, with the intention of passing:

> …from an education centered on the sick patient seen in the office to one in which the impact of the harm on families and communities could be appreciated, according to the environmental conditions of their immediate surroundings. For the first time, the preparation of medical students in the hospital was expanded to family and community environments. (21)

This contrasted with the Colombian health care model, characterized by its centralism and the existence of a network of centers, health centers and local and regional hospitals (22). The conclusions of Alma Ata (1978) and the Ottawa Charter (1986), among others, had an impact on public health policies and generated the need to include community environments in the training of physicians (23, 24).

At that time, Colombian medical schools such as the Juan N. Corpas University planned community medicine scenarios that continue to this day. Jiménez (25) affirms that these scenarios and the extramural activities developed there allow more people to benefit and students to acquire new knowledge, skills and aptitudes, with a different and comprehensive approach to health (26).

The UTP medical program did not remain oblivious to this trend and included, from the beginning, community scenarios for health practices. Villarreal (27) affirms that community cultural practices related to health have a symbiosis between education, prevention, and health promotion as essential elements of the health-disease process.

Finally, studies similar to the one presented in this article confirm the potential benefits of community practice settings. Some outstanding opinions in this regard are the following:

> It is a good experience. Good way of approaching the community, valid for the whole career. It fostered in me the vision of the physician as one who promotes and prevents and not only as one who cures. Every year we should have experience with the community. It taught me to live with different people and realities. It allowed me to get closer to my colleagues in the Basic. It was great, I hope it continues every year. This experience should be considered during the whole career. (28)

Conclusion

This research identified and analyzed the imaginaries present during the process of creation and design of the UTP physician profile. The information provided by the project managers and first graduates refers to the discussions about the health situation at the national and international level at the time and is expressed in the original document of the curriculum, elaborated in 1976. Many of the accounts coincide in important aspects such as the need for a humanistic physician, committed to the community and willing to provide a comprehensive response to the needs of the most vulnerable populations.

These representations of the profile coexisted with another group of imaginaries, related to a low quality physician, not very rigorous in his scientific work and focused on the performance of low complexity activities, probably based on the criticism of the models of medical care and training implemented in China or Cuba.

Understanding the conditions of the environment and the arguments surrounding the creation of the UTP School of Medicine increases the historical information available. This promotes reflection on whether those initial motivations and considerations are still preserved in the profile of the physician graduating from the program today.

Conflict of interest

None.

Bioethics statement

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