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Family and Community Medicine in Uruguay from 1997 to 2019: how many kilometers will it take to reach that town?

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Abstract *The Family and Community Medicine Residency started in Uruguay in 1997. Through a self-managed process, the first generations were molded into training that integrated hospital knowledge and experience with territorial praxis in a community-based health service with a population of reference. The academic recognition of the specialty and the installation of the institutional areas for its management were achievements parallel to that process in the first decade. The second decade was marked by the territorial teaching-assistance expansion in the country, university decentralization and the active participation of Family and Community Medicine in the Health Reform, and the country's rights agenda. The third decade of the specialty begins with a crisis triggered by the sustained decline in the aspiration for residency. An initial approach to explanations reflects on the possibility of facing a more profound crisis and the need to find the keys to a 21st century Medicine that allows us to achieve the principles of Alma-Ata that are still current.*
Key words *Family and community medicine, Staff development, Primary Health Care, Workforce*

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Introduction

The condition of a member of the first generation of Family and Community Medicine (MFYC) residents in Uruguay, as well as having been coupled with the training of specialists since that early and post-first year 1997 (resident, then tutor, then teacher), allows us to tell the "inside" story. Since this is an opinion paper, subjectivity often not admitted by science can flow at will, seeking to provide a perspective that is often difficult to find in complex processes if it is not from there.

The end of the twentieth century, where the onset of residency in Uruguay was recorded (the last piece missing from the map of South America to complete the puzzle of Family Medicine/MFYC specialization), was a special moment. Not so much for the mystical or astrological omens for the millennium change, but for the vertiginous processes in the development of computer science and the internet that – spearheaded by Gates and Jobs – would drastically change the world in the following decades.

More than twenty years later, out of order and accommodated again after the changes, a similar breeze can be intuited in this new decade change where technological advances, from robotics and biotechnology, among others, will shake the stage again. We know that changes will come, but we are unaware as to how much they will affect us.

Threats are also struck by climate change, with a growing tension from the economic model in all life processes. Tangible facts with social, political, and health repercussions affect a subcontinent extraordinarily rich in culture and nature, more and more overwhelmed by the extractivism that ignores the value of life in favor of profits.

Chilean agronomist and teacher Alejandro Rojas worked alongside Paulo Freire from the Federation of University Students in the literacy campaigns of the Allende government. An advocate of agroecology and production on a human scale, Rojas introduced the concept of "polycultures of the mind", which is based on the original idea of Vandana Shiva, who says that the "monocultures of the mind[1]" are the way of research and knowledge produced in controlled environments. In contrast to that form of knowledge shaped by the Northern cultural project, Rojas describes the knowledge produced locally as follows:

"Peasants require detailed and deep knowledge of their ecosystem. They are rooted in their physical places, which equips them with a type of engaged and participatory knowledge, instead of the uprooted and remote knowledge that often results from the scientific practice of industrial agriculture. They positively value personal experiences and beliefs as resources of knowledge instead of seeing them as an obstacle to understanding the world. It is local knowledge that focuses on the interests of the local community[2]".

Family and Community Medicine in Uruguay has been forged as a "polyculture of the mind." Some result is achieved from singular experiences in which the in-depth knowledge of the context and the involvement of its participants was not lacking. It is fully compatible with the description of polycultures made by Rojas: "knowledge that attempts to reproduce and assimilate the complexity and uncertainty of life, accompanied by learning processes that inspire the opening of the individual and collective mind of a learning community through feasible and tangible objectives[2]".

This text is produced from lived experience and reflection. The documents produced during this time are mentioned, but what is documented of an experience that has not left enough time to write it is still scarce. In this sense, this paper helps pay off part of that debt.

Learning spaces

The Fourth Family Medicine Congress and the Third Seminar of the Southern Cone Residents were held in Montevideo in 2000. The first year of the new millennium was also that of the graduation of the first generation of residents. That event took place in a climate of uncertainty. A residency program completely formalized by the National Technical Commission composed of the Faculty of Medicine and the Ministry of Public Health was in place. There, from the proposal of a surgeon, then President of the Commission, and the confluence of wills that facilitated the votes for the decision, the initiative to open the Family and Community Medicine residency had been taken even when the Faculty (represented in that Commission) did not reach a consensus to accept it.

In Uruguay, undergraduate and graduate professional degrees are administered and certified by the Universities, not by colleges or professional associations as in many countries. At the University of the Republic (which holds more than

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90% of medical training in the country in all its branches and levels), the competence in medical specialties falls under the Graduate School linked to the Faculty of Medicine.

By then, the Graduate School not only ignored the process initiated with the Family and Community Medicine residency but was also opposed to the specialty. The materiality of four professionals who graduated from the residency on March 31, 2000, contrasted with the assertions of the Graduate School denying the existence[3]. While this denial of which we were subjected for several years was a cause of struggle[4,5], we never doubted that the story would go in the expected direction and that we would arrive "sooner rather than later" to receive the title of specialists, and – the fundamental thing – the recognition of the specialty by the University of the Republic, which would represent the definitive legitimation of Family and Community Medicine in the country.

We were concerned about "the learning spaces" at the time. Uruguay installed the National Integrated Health System in 2008. The health organization was fragmented before the reform, with multiple public and private, poorly coordinated effectors. The resources were concentrated at the hospital level, and the undergraduate and graduate training of health professionals was held there. The first level of care was low, barely hierarchical, poorly professionalized, deficient even in the State Health Services Administration (ASSE), although it had a historical network of polyclinics and health centers throughout the country.

The need for first level development was evident. From the residents' perspective, this development was necessary not only to improve the system of care but also as a "learning space". The matter was there as a necessity, an outline of an ideal to be achieved, a longing. The residency had started with the only possible perspective then: on the one hand, the hospital, and on the other, tutors[6]. Tutors were appointed by the National Residency Commission, recognized doctors who, without a specialist title (something not possible in that Uruguay), had an exceptional practice, based on the principles of Family and Community Medicine, established in a first-level health service, with a reference population[7,8].

In the hospital, references were Pediatrics, Gynecoobstetrics and Internal Medicine Clinics, the Outpatient Services of some focal specialties such as ophthalmology, otolaryngology and dermatology, and the Emergency Departments. For the professors in charge of these services, the first news of the MFYC residency was our arrival the day we had to start the internship. We arrived with the Two-Page Program that simply indicated that we should be there. The task of each resident was to report what the "new" specialty was about. The objectives and implementation of the internship was something that had to be built with the hosts from that moment. It was not written anywhere, but at that time, it was clear to residents and teachers that there was no other way.

While the hospital activity began to be questioned as a training space for a specialty dedicated to community-based exercise (at that time, it represented between 90 and 70% of the 48 weekly hours, decreasing over three years of residency), it was not a problem for the first-cohort residents. Receptivity had been excellent, and the possibility of having qualified teachers outside the hospital was minimal. Also, the experience of sharing learning in the admission or emergency room working alongside residents of pediatrics, gynecology, internal medicine, surgery, psychiatry, among others, was a path of mutual recognition that erected solid foundations for the acceptance of the specialty in the world of the predominantly hospital-oriented medicine at the time. We felt could make the "translations" necessary to take hospital learning to the community level, and regular tutoring activity played a fundamental role in that process.

We were not dissatisfied with our self-taught and self-managed residency. This condition of apparent insecurity was a value in itself and made the training process a leadership path for the construction and stance of the specialty. However, we knew that those conditions were not the ideal ones. We knew of the need for *learning spaces* that could accommodate residents in a place in the health system closer to the people than what the hospital represents, and that could allow the development of all those processes that we already knew were part of the specialty and, therefore, should be part of the training path.

We talked about spaces for care, research, the family approach, and the community component. We identified that the following were necessary:

Care spaces: Health services organized for the office and home assistance work that can maintain adequate coordination with the hospital and specialized referral services for patients, whether

through letters, visits, follow-up of patients by residents.

Equipped spaces: Health services with adequate and sufficient resources and supplies to solve the main reasons for visits of the population of all ages, even in urgent and emergency situations, primarily when health services were located in rural areas.

Spaces adapted to the Family and Community Medicine model: With the necessary resources for the anthropometry of children and adults, gynecological and conventional stretchers, with the possibility of attending people of all ages and receiving several family members in the visit.

Study spaces: Having access to books, magazines, updated bibliography within the care workspaces, as well as time and organization necessary for reading as part of daily work, based on the concerns of the clinic, or for scheduled group reading sessions.

Quality spaces, with rigor in processes and records. Particular emphasis on the use of medical records, preferably in family format and the use of a genogram.

Research spaces: Quality clinical records, the primary input for clinical research in the first level of care. Epidemiological approach to the community to understand their needs and problems better.

Community spaces: Access to meeting rooms, time for community activities, and development of group strategies.

Approximately, this was the description of the "learning spaces", drawn from the resident experience, presented during the 2000 Congress[9]. This unpublished collective thought has guided the course covered in the following two decades.

The dialectic of the beginnings

A feeling that prevailed in the resident at that time was that of "processor". There were worlds of needs (ideal sketches) and worlds of possibilities (imperfect realities). Nothing was done, but we were given the possibility of building from and to the measure of each. Without prescriptions (the Residency Program was limited to those two pages that set out a list of mandatory rotations and the workload), there was a vital and formative experience of each resident with their tutor, and their paths; from the rural home to the delivery room, from hospital mornings and emergency nights to afternoons with children in schools.

The experience was enriching the ideas, the initial designs, and throwing inputs to perfect that "ideal" residency model where we dreamed of a structured Program, teachers of the specialty, and academic fields recognized in the first level.

The dialectical interaction with everyday events, the context of freedom provided by the flexibility of the program, and the constant production of new facts and results tailored to the needs, was what made us feel like living "processors": the processes lived transformed us, but we also transformed. Everything happened on an individual/local scale that was broadened as the experiences were integrated and transcended to the institutional level that even reached the national level.

Looking back at that time, which from a curricular perspective can be weak (a two-page program), the richness of production (of ideas, facts, changes) must be revived, as well as the strength of the training achieved through these chaotic, but productive processes as long as one offered himself/herself as a "processor" to be transformed by them; which was not so innocent because that was what allowed to transform, we knew it[10].

The teaching assistance units

The years 2007 and 2008 were intensely legislative in Uruguay. Very relevant health standards were produced. Law 18.211[11], on the establishment of the National Integrated Health System, which gives way to the most critical health reform in the country's history, is from 2007. Then, the Accountability Law passed in 2008, leads to the creation of the "Program for the Training and Strengthening of Human Resources of Public Providers of Health Services" (PFRHS)[12]. This Law opens a new budget line that allocates resources for joint management by the Faculty of Medicine (University of the Republic) and the State Health Services Administration (ASSE) (state provider of the SNIS that houses most of the training of health professionals in the country). This allocation of funds opens the possibility of creating Teaching Assistance Units, primarily in the first level of care. The nomination of projects and teams with territorial base is called. Thirteen projects approved in 2008, located in six of the nineteen departments of the country, were the beginning of this program. They were installed in April 2010. In the second stage, new

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rural projects were incorporated, which extended coverage to ten departments.

The PFRHS established criteria for the selection of projects as a way to promote some of the objectives of the program: work concentration, the position's tenure and team stability, as well as the protection of the teaching career and cooperation in teaching work by professionals without teaching positions but endorsed by the Faculty.

The 2000 design is still found ten years later in the organization matrix adopted by the first-level Teaching Assistance Units.

Teams with diverse numbers and integration were found in different parts of the map, predominantly but not exclusively of Family and Community Medicine (pediatricians, obstetricians, psychologists, psychiatrists, epidemiologists, nutritionists, gynecologists are also part of the teams), giving rise to a new process of dialectical construction as productive as the onset of residency. This process allowed the full materialization of those "learning spaces" in the territory, overcoming the many fragmented services of the first level, to install a process rationale, teamwork, and comprehensive, longitudinal, and continuous approach. These new spaces, consisting of health services and their territories, became the curricular reference areas for all Family and Community Medicine residents.

After a slow process since the initial "denialism" of the Faculty of Medicine in 2000 and previous years, the Department of Family and Community Medicine had completed its institutional consolidation process in 2007. In 2010, it advances substantively to its decentralized development, with a central academic-administrative base, and an extensive territorial network of Teaching Assistance Units where all the assistance and clinical-community teaching-learning activity takes place, both for undergraduate and graduate students of the specialty.

The ten years that separate us from that second founding moment have been of intense work, of local developments, of maturation and creation, but also, more recently, of crisis. We shall discourse on this later.

In-depth in another millennium

In a much denser matrix than at the beginning of the residency, with specific Family and Community Medicine teaching teams dispersed in the territory, second-decade residents have also had a significant creative role. In tune with the socio-historical context, they have participated in the commitment assumed by the specialty with the rights agenda that filled the social and political scene in Uruguay in recent years. Access to sexual and reproductive rights, including risk management and harm reduction due to voluntary termination of pregnancy, comprehensive care for trans people and all sexual diversity[13], as well as accessibility to care for people living with HIV, had the work, contribution and commitment of teachers and residents to incorporate these processes into first level services. Care to persons deprived of liberty, the community perspective of mental health, care to migrants from the perspective of interculturality and the in-depth gender perspective in health care, are today in the Family and Community Medicine's agenda, are part of their daily lives and translate into academic production and design of processes for care, management, and networking.

This production arises from the new framework that supports the training of residents and is possible from the teaching-learning contexts of a territorial nature established through the first-level Teaching Assistance Units.

Of course, this happens without neglecting the problems that are traditionally part of medical work: non-communicable diseases and their increasing prevalence, health care at all stages of the life cycle including reproduction, palliative care, problems related to violence of all kinds, problematic substance use, nonspecific infections, reemerging tuberculosis, among others.

For both the more traditional problems and the more recent concerning incorporation, the challenge of the management and design of accessibility strategies in a National Integrated Health System that enables and mandates is permanent, but that does not always secure the necessary resources. Team creativity in the territory, including inter-institutional coordination, is part of the micro and meso management processes that residents address and resolve daily as part of their training. Again, it so happens that there is no planning or a scheduled curriculum for each step and stage, but again, the process, in its chaos, appears to be productive and transformative.

Crisis

In its article 34, the Law of the establishment of the SNIS says:

"The National Integrated Health System will be organized in networks by levels of care as per the needs of the users and the complexity of the benefits. Its strategy will be primary health care and prioritize the first level of care[11]".

With the Family and Community Medicine residency consolidated and achieved academic legitimacy (not without persistent tensions), a period of a real hierarchy of the specialty in the field of training emerged. The number of residency positions was increasing over the years, strategies for filling vacancies were applied, offering the positions to contestants who had been approved in another primary specialty (pediatrics, gynecology, internal medicine or surgery), and admission to the career of MFYC specialist through the postgraduate degree in an "inland scheme" (which provides flexible hours and other advantages for people living far from university centers). ("inland scheme").

In Uruguay, residency exams are annual, there is only one public examination for the whole country in the same place, day and time, but with a test and a proper board for each specialty.

The health reform did not modify the (state and non-state) health care institutions that existed in Uruguay but instead called them to be part of the National Integrated Health System as comprehensive providers, subject to the operating rules set forth by the Law and administered by the Ministry of Public Health and the National Health Board. Before and after the reform, the residency positions are the product of the will of the effectors that finance them and propose to the National Commission for approval. The final decision also takes into account the availability of academic support in consultation with the respective Chairs and Departments of the Faculty of Medicine for each specialty.

ASSE is the leading health effector of the country and the largest financier of residencies; consequently, it is also the most critical specialist training field. Other collective, state, and non-state medical care institutions offer a lower proportion of residency positions. The Faculty of Medicine is responsible for the public examination. A single program is in place for each specialty, and these are regulated by the Graduate School of the Faculty of Medicine. Each Department or Chair of the Faculty of Medicine is responsible for academic compliance with the Program during residency, and for ensuring the resident training conditions.

Another characteristic of Uruguay is that it has not defined a human resources health policy from which the distribution of residency vacancies or the number of professionals recommended for each discipline or specialty is decided. The number of vacancies offered and their distribution is agreed every year by the National Commission from the mentioned parameters: the vacancies offered by health providing institutions and the capacity of the Chairs and Departments to ensure academic training.

Some non-surgical specialties admit entry through the postgraduate route without residency (unpaid), such as Family and Community Medicine since 2003. Applicants must also compete and pass the residency test for admission. This type of admission is a minimal proportion in the Family and Community Medicine, except in 2012, as will be discussed later.

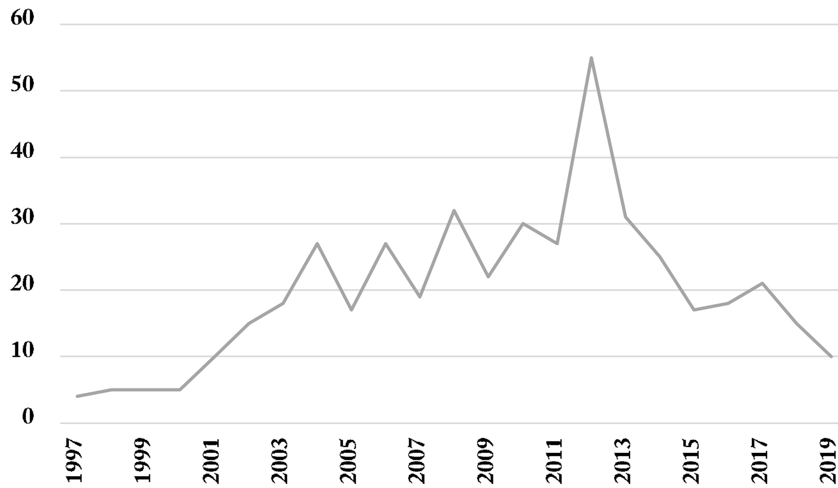
Graph 1 shows the number of admissions in the specialty from 1997 to 2019, and Graph 2 shows the annual variation of this indicator.

The peak recorded in 2012 corresponds to the opening of the postgraduate program in the inland scheme, which had a massive admission of 23 postgraduate non-residents, but had no continuity over time. This same year recorded a peak number of resident spots.

Graph 2 shows that until 2012, annual swings in the number of admissions are noted, with elevations and declines, and the increasing trend predominates. As of 2012, the negative component becomes dominant, and the data reach nine admitted residents in 2019. This number is only comparable to 2001 and is the lowest since then. Unlike those ten positions, which were the total quota for MFYC in 2001 and a quota on the rise after calls with four and five positions from 1997 to 2000, in 2019, the number arises from the under-occupation of available places, and a quota decrease due to reiterated vacancies.

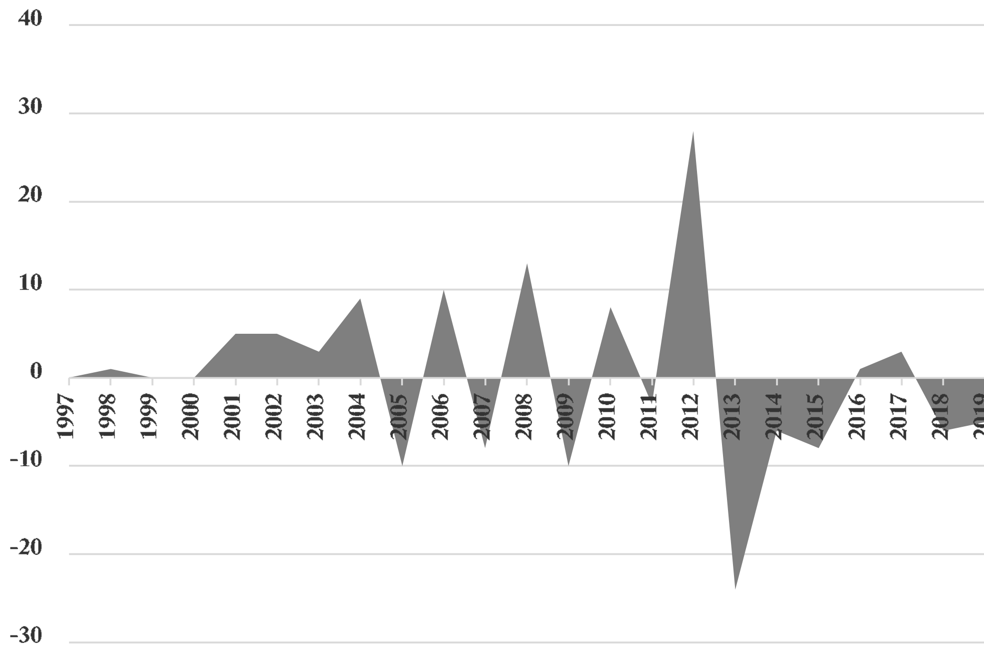
The sustained decline in admissions with under-occupation of the seats offered has conditioned the loss of positions in recent years. As stated before, distribution decisions are annual and taken within the National Commission, without a strategic guiding plan. Under these conditions, the repeated under-occupation of places is a negative pressure for the maintenance of a high number of vacancies.

The search for explanations for this crisis is a matter of study at this time. It is known that it is not an isolated problem in Uruguay, and that



Graph 1. Admission to the Family and Community Medicine Postgraduate Course and residency since its origin: Uruguay 1997-2019.

Source: Own elaboration.



Graphic 2. Annual variation in the number of Family and Community Medicine Postgraduate Course and residency admissions, Uruguay 1997-2019.

Source: Own Elaboration.

despite the discourses and health reforms that favor primary care, the prestige of work at the first level of care, as well as the remuneration of professionals, are at a disadvantage compared to focal specialists and hospital performance.

In a brief exploratory study carried out in August 2019, short distance interviews were conducted with residents, teachers, and other related to Family and Community Medicine; and with advanced medical students and residents of other specialties[14]. We inquired into their vision of the reasons for this decrease in the aspiration to Family and Community Medicine residency. The results reveal, inconclusively, that some of the aspects would be the low prestige of the specialty ("hospital status"), the deficient knowledge of the specialty by students and the population, and the adverse working conditions: work and emotional overload, jobs in complex social contexts and low pay comparatively with other specialties.

The low presence of MFYC in non-state SNIS providers, which cover 60% of the country's population, was also identified as a negative influence.

Another aspect, contributed particularly by the youngest, was the preference for "simpler", "less complex" specialties. The preference of a performance unlinked to uncertainty would weigh in their choice.

Is Alma-Ata far?

Alma-Ata is a city, and also a Declaration pronounced in 1978[15], in a city with a peculiar name, in a country that no longer exists. However, for many, it is a beacon that has not been replaced by any of the subsequent documents, nor by the most recent Declaration of Astana[16].

While we consider the challenges of the future and the difficulties that are seen with this shortage of residents that will quickly translate into a shortage of specialists and repercussions on the pace of change in the care model, it may sound odd looking at the past.

If we measure time since then regarding Uruguayan history, one can say that, of the forty years that separate us from Alma-Ata, we hold the first twenty to decide to install the Family and Community Medicine residency, and the next twenty years to develop it. Seen from this angle, Alma-Ata does not seem so far away, and time to accumulate the first number of professionals with maximum competence for the development of its strategy has hardly been enough. Nevertheless, in the face of the current crisis, it is worth asking whether we will begin to move away.

The conviction that the territorial and complex support of the specialty places it in the right place for the health problems of the 21st century – to monitor, care and also to investigate and manage – seems to collide with the aspirations of the youngest who prefer a more stable and predictable professional life.

The crisis we are witnessing could be more profound than the decline in the Family and Community Medicine applicants. It could involve Medicine, not just the specialty. The commitment to historical time and the stance in the construction of the new are natural conditions to be professional, regardless of the profession or specialty. The possibility of facing a crisis of professionalism in Medicine, or the potential effects of the commercialization of health on the profession, appear as too simple hypotheses for a complex problem, but they are ideas to keep in mind in the search for explanations.

Going back to the past does not seem to be the solution (although Alma-Ata is still in force). It would be about trying new paths, creating, renewing, and innovating. The challenge would be to make Family and Community Medicine a desirable life option for young professionals of the

21st century, without this meaning renouncing Alma-Ata or any of its principles.

Again uncertainty, the breeze that smells like changes, technology pressing under our pillows, Family and Community Medicine, health systems, managers who trust numbers more than people, people with their increasingly diverse, increasingly complex problems, the fast-track thought circulating in social networks. Everything is there. Everything is here.

Rethinking in the medical profession for the 21st century seems to be a necessary matter before resuming the issue of family and community medicine, old and new designs, and ask ourselves again, "how many kilometers will it take to reach that town"[17].

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