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Curricular Analysis of the Medicine Career at the University of Buenos Aires

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Abstract

The curriculum is a set of formal and informal experiences that are integrated into the curriculum of a university profession. In educational institutions, two types of curriculums coexist: the planned one, in which the intention of the proposed objectives is expressed, and the hidden one, which does not appear in the study plan and is structured in the set of attitudes and norms that are transmitted to through identification models. The curriculum must provide the student with a methodology that allows them to continue learning, and must express a conception about the evaluation, establishing the main guidelines on the system of promotion of students and what are the requirements and conditions to advance in the study. In the present work the study plan is analyzed from the curricular vision of the composition and extension of the medicine career of the faculty of medical sciences of the University of Buenos Aires (UBA). It is concluded that the study plan must be updated contemplating the medical professional model that society requires, and the total extension of the career must be reconsidered.

Keywords: University curriculum, Medicine career, Curriculum change

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Introduction

The curriculum is a set of formal and informal experiences that are integrated into the curriculum of a university profession. In educational institutions two types of curriculums coexist: the planned, in which the intentionality of the proposed objectives and the hidden is expressed, which does not appear in the curriculum and is structured in the set of attitudes and norms that are transmitted to through identification models [1].

The curriculum must provide the student with a methodology that allows him. The curriculum supports the principles set forth in the international conference of Alma Ata, organized by the world health organization and the pan American health organization in Kazakhstan on September 12, 1978, which consecrated primary care health [2-4].

The medicine career issued at the UBA, is composed of an initial biomedical cycle, a second clinical cycle and ends with an integrative practical theoretical learning cycle, which is carried out in the hospital teaching unit (UDH), called annual rotary (IAr) internship.

The graduated student must have sufficient knowledge that allows him to join the postgraduate training program, either in the program of programmatic residences and concurrences or his insertion in the workplace.

Aim

Analyze the curriculum from the curricular vision of the composition and extension of the medicine career of the faculty of medical sciences of the UBA.

Material and Methods

The current curriculum approved by the resolution of the rector of the UBA is analyzed resolution of the higher council of the UBA file 2,086,325 and 24,635/09, of December 16, 2009, and resolution no. 7591.

Results

The medicine career is a degree race that lasts eight years and is divided into four cycles: the common basic cycle, the biomedical cycle, the clinical cycle and the final cycle called IAr internship.

The total hourly load is 8140 h, including the CBC (Exp - UBA: 2,086,326 and 24,635/2009 - resolution no. 7591). The theoretical minimum duration of the race is 7 school cycles.

- The common basic cycle is 512 h (6 subjects).
- The 1866 biomedic cycle (12 subjects).
- The 3622 h clinical cycle (25 subjects).

The integrating cycle (IAR) 2140 h and contemplates 7 subjects to be carried out at the UDH.

Discussion

The curriculum is a set of formal and informal experiences that are integrated into the curriculum of a university profession. The formal curriculum is contained in the objectives of the teaching of each subject and that develops in theoretical and practical learning, while the informal one enrolls in the exercise of practical work, in which the student shares knowledge and experience of the teacher or instructor in charge of practical work.

The career in its curriculum supports the principles approved in the international conference on primary health care, Alma Ata, whose paradigm supported the primary health centers as the first step in access to the health system, mainly in the preventive area.

The learning of medicine, the acquisition of skills and abilities and the IAR is going through a period of morphological, macro and microscopic, physiological study, with the basis in chemistry, biological and anatomopathological physics that develops in the faculty. Then the clinical cycle and the IAR are fulfilled in the UDH, with theoretical classes and practical works that position the student together with the patient, with the supervision of the teacher.

The teaching-student relationship can be quantitative or qualitative. It is designated as quantitative, because the number of students conditions proximity to the teacher, communication and knowledge exchange (formal curriculum) and the acquisition of professional experience (informal curriculum). And in turn it is qualitative, because the instructor must possess the knowledge of the subject and teaching skills in terms of their pedagogical and didactic preparation for university teaching practice.

These facts determine that the teaching relationship quantitatively and qualitatively is irreplaceable for the student.

This teaching-student analogy is essential for student teaching and is the support of the process of acquiring knowledge, theoretical foundations and practical exercise, and the awakening of interest in the search for bibliographic information, expanding the content of the class of the class theoretical in this way, the training of the professional future is acquired in the face-to-face mode, irreplaceable in the 3 cycles that make up the degree career.

The curriculum contemplates the teaching of the theoretical and practical objectives of each subject, adopting the paradigm of primary health assistance.

The graduated student must have sufficient knowledge that allows him to join the postgraduate training program, either in the program of programmatic residences and concurrences or his insertion in the workplace.

The exercise of medicine is inscribed in the social function of care and restoration of health, contemplating the individual and collective health, depending on prevention, prophylaxis, early diagnosis and access to care and diagnostic methods and therapeutics of the individual and the social group [5].

Medical knowledge, knowledge of our time expands daily and access to information requires opportunities and accessibility to information. The update is constant and is combined with the exercise in real time.

Virtual libraries demand the acquisition of physical and connectivity resources to networks. Information and communication techniques (ICT) have replaced the search for face-to-face information by expanding the spectrum of information sources and the knowledge acquisition modality.

The curriculum must incorporate ICT and distance communication (virtuality) expanding access to information but cannot replace face-to-face.

Exercise models in simulators will complement practical activity but cannot replace the patient medical relationship.

Candreva and Morandi [6], observe attempts to characterize the senses with which theory and practice are linked in some theoretical perspectives, as well as the possibility of developing practical knowledge. One of these characterizations is Aristotelian differentiation between the three types of knowledge: technical, practical and theoretical.

In general terms, technical knowledge is considered as the implementation of pre-established procedures to be carried out in preached situations and practical knowledge such as knowing how to do or knowing how it is done. According to De León [7] (French sociologist) was what it is about, different from the position of Schön (American philosopher) that characterizes him as a knowledge in action [8]. Theoretical knowledge would be one that constitutes a generalization and abstraction of specific situations, this is their modeling.

In medicine, career theoretical knowledge is ascribed to the biomedical cycle, continues in the clinical cycle, while the technical and practical one begins in the UDH and continues in the IAR.

The acquisition of the knowledge, skills and skills are conditioned by several factors including the number of students, the number of teachers, the physical resource in the UDH and in time assigned to the practical work of each subject in the first two cycles of the career.

The IAR is a bridge between the student who has approved all the subjects of the biomedical and clinical cycles and that will complete their training in an integrative cycle, still as a student, but applied to the exercise of medicine in the hospital. During this cycle, the student will rotate 2 months in the services of medical clinic, general surgery, tocogynecology, pediatrics, mental health, primary health assistance, family medicine, and hospital emergency.

After the IAR, the student graduates from the faculty and receives the qualifying degree but must still complete his professional training in a structured activity (residence or concurrence) of preference. Postgraduate training programs are not part of the degree teaching curriculum.

The biomedical, clinical and IAr sequence is a succession of stages that require correlativity's and the final approval of each subject (either promoted or by summative examination), which develop progressively towards contact with the person, with the individual and the medium hospitable. The person represents a physical and social psycho subject, who takes place in a certain geographical, social and productive environment, traveling the balance of the health binomial, in a given scenario. Student's education in the biomedical cycle develops in the faculty, away from the hospital or institutional health environment, where he will develop professionally.

This distance is not shortened in the clinical cycle, but on the contrary is decoupling from the initial training, introducing the student in each subject as a mosaic of dismantled knowledge.

The IAR is proposed to integrate knowledge, but its weakness consists in its duration compared to the extension of the degree career.

As of 2020, Covid pandemic-19 imposed curricular change in the face of the government decision to maintain university education, adapted to the conditions of virtual modality, according to the human and material resources of the faculty.

Virtuality imposed modifications in the teaching process, and despite the efforts made to sustain academic activity, didactic innovations could not replace the personal relationship between students and teachers. Even less, the semiological practice of fundamental link in the formation of future doctors, could reach the standards prior to the pandemic [9].

However, the operation changes, the general objective with which the UBA forms its doctors has not changed. The orientation in the training of health professionals, nests in the foundations stated in the primary health care.

Centeno [10] points out that the educational context, defined as the physical, cognitive or affective environment in which an educational action is carried out, is one of the most transcendental aspects when planning and implementing a curriculum, and cites. Koens et al. [11], who proposed a theoretical model that defines the context in three different aspects: the physical aspect of the environment (classroom, community), related to cognitive aspects, from learning the facts or isolated topics to integrated learning and the one related to the affective or motivational aspects of learning (from learning for a class or for an exam, attending a patient or only out of intellectual curiosity).

Conclusion

Adaptation and curricular change will demand a process of transformations that reach institutions and impacts teaching human resources, while expressing the modifications operated in society in close relationship with the evolution of the knowledge of medicine, the medical knowledge of the medical knowledge of the present in constant progress and expansion, and social, economic and political conditioning under which society develops.

The update of the curriculum must contemplate the medical professional model that our community requires and prepare the young doctor graduated to continue their training either in an intensive program, residence or concurrence, a career of university specialization, as well as in continuous training in professional practice.

Undoubtedly, the extension of the race in time must be a variable to consider when designing a curricular change. Adapting knowledge and knowledge of the present in a new curricular design is our next challenge. Time is a dimension that we cannot recover.

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None.

Conflict of Interest

None.

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