Beatriz Aragón Martín, Adrián Carrasco,
Marta Pérez, Estrella Sánchez-Gamborino,
Ana Zamora:

»Rupture & Reparation«

in: Dominik Mattes, Janina Kehr, Julia Koroknai,
Friederike Rosenbaum, Helmar Kurz, Claudia Lang,
Caroline Meier zu Biesen, Ehler Voss (eds.):

cache 04

RADICAL HEALTH

intercomverlag, Zürich 2025

RUPTURE & REPARATION Talk We Must

We write this paper from a shared state of disorientation. Our starting point is a question: what has happened to us since the winter of 2020? Can we share the experiences we did not have the time or energy to share during the worst part of the pandemic? What use can we make of these experiences stored in our memories? We are part of a larger and heterogeneous group in Madrid that tries to work in community healthcare: we come together participating in research projects, attending discussions on social determinants of health, working as professionals in primary health care (PHC) centres, engaging in mutual support groups to fight poverty and healthcare exclusion in different neighbourhoods, or writing pieces like this that help us get together, interrupt the accelerated time we live in, and reflect on what these experiences mean to us.[1]

"Think we must. Let us think in offices, in omnibuses, while we are standing in the crowd [...] let us never cease from thinking - what is this 'civilization' in which we find ourselves?"

Virginia Woolf: *Three Guineas,* New York: Harcourt, Brace and Company (1938), pp. 94–95; quoted by: Isabelle Stengers, Vinciane Despret: *Women Who Make a Fuss: The Unfaithful Daughters of Virginia Woolf*, Minneapolis: University of Minnesota Press (2015).

Since the summer of 2020, our discussions have revolved around the loss of common sense: in the post-pandemic context, both healthcare workers and citizens express serious concerns about the meaning and value of the work being done in PHC centres. The term we have come to use in these discussions is rupture: rupture between ourselves and PHC work, between PHC centres and their territories, and between people and PHC. How can we reflect on these ruptures? How can we repair them? These are the two main questions we address in this text, which is a collage of voices, thoughts, and experiences from people both from inside and outside primary healthcare. Thinking together, we attempt to initiate a process of reparation, to bring together the broken pieces of the ruptures we suffered individually, to rescue those pieces that are still valuable, and to build something anew. By doing this, we locate ourselves at a sort of threshold between inside and outside and find the urgent need to connect the two sides as a collective endeavour.



Asociación Valiente Bangla*, Red solidaria de acogida and Red interlavapiés*, 2020.

"How can I take care of myself if those who take care of me do not understand me?" (Authors' translation). This flyer was issued by the campaign to claim language interpreters at the PHC centres promoted by several neighborhood associations. Although the flyer specifically refers to communities that do not speak fluent Spanish and need an interpreter during healthcare visits, it can also be understood in a broader sense: what happened in PHC centres during the pandemic such that they no longer understand what people are going through? Were we so happy together before? If in her book, *Three Guineas*, Virginia Woolf urged us to think, we feel that to think we must talk to each other.

RUPTURE & REPARATION Tensions

The *Marea Blanca* movement brought together healthcare workers and citizens who accused the government of politically motivated neglect of the public healthcare system.[2] A flashy sign hanging in the gynaecologist's waiting room advertised the sale of the obstetrics and gynaecology service as if it were a real estate property. Such signs are normally used to advertise a house for sale in Spain. This kind of protest highlighted the fact that the regional government was selling a public good for private interest.



Photograph by Beatriz Aragón (2013).

Healthcare worker showing her support for universal healthcare in her workplace.



Photograph by Beatriz Aragón (2013).

"Gynaecology and obstetrics for sale" (Authors´ Translation). The pictures were taken inside a public healthcare centre in Madrid in 2013 in the aftermath of the financial crisis. It led some European countries such as Spain to implement austerity measures that took a great toll on public services. Budget cuts were accompanied by a national structural shift that altered the universality principle of the National Healthcare Service (*Sistema Nacional de Salud*, SNS): in September 2012, a Royal Decree-law came into force, excluding undocumented migrants and other groups from healthcare and thus undermining universal coverage. While the initial response brought together professionals rejecting the law, media reports on the gravity of the effects of this exclusion, and collectives organizing mutual support to fight for universal access on the ground, healthcare exclusion compounded processes already in place in PHC. These processes included the prevalence of individual versus collaborative interdisciplinary work within the PHC centres, coupled with the increasing precarity of workers and bureaucratization, which very often contributes to racist practices. Furthermore, some regions, such as Madrid, profited from the austerity measures and the budget cuts, which made it easier for private companies to run public healthcare facilities. Out of the popular discontent generated by the cuts to public services, such as the *Indignados* movement, also called *15-M*, a widespread movement called *la Marea Blanca* (*The White Tide*) arose to defend the SNS from the attempts to privatise it.

Before the COVID-19 pandemic, PHC in Madrid was not at its best: underfunded and marginalised in a hospital-centric system, it had progressively lost most of its communitarian foundations.

To better convey the tensions underlying PHC, we need to provide some context about healthcare in Spain. The Spanish healthcare system, *Sistema Nacional de Salud* (SNS), was conceived in the eighties during the transitional years to democracy after the Franco dictatorship. The SNS is a decentralised system (every regional government oversees the provision of healthcare) financed through general taxation that originally aimed to provide universal health coverage. PHC was conceived as the basis of the SNS, theoretically grounded on George Engel's biopsychosocial model and the Alma Ata principles in which essential healthcare is "made universally accessible to individuals and families in the community through their full participation".[3] However, this kind of community-based care was not developed in all PHC centres, neither in Madrid nor at a national level. We need to add to these tensions the fact that PHC has never been one of the most appealing medical specialties: it has little social and medical recognition in the Spanish hospital-centric context.

"The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources."

Julian Tudor Hart: "The Inverse Care Law", in: *The Lancet* 297/7696 (1971), pp. 405–412, p. 405.

"I have witnessed and experienced the processes that have eroded the communitarian foundations of primary healthcare little by little. Although the Marea Blanca movement succeeded in stopping the privatisation of 6 hospitals and several PHC centres, the achievement did not translate directly to our workplace, where we had to manage everyday work with fewer resources due to the continuous budget cuts. The increasing workload diminished the capacity of healthcare workers and their enthusiasm for the defence of the SNS. The picture of the paediatricians' door at the PHC centre shows how overwhelmed many healthcare workers felt. On the paediatricians' closed door, different messages warned patients about what was considered an adequate use of the healthcare system with the purpose of avoiding the collapse of the system. The use of these closed doors to communicate with people is a metaphorical representation of the rupture between healthcare workers and the rest of us: a shift in this relationship whereby healthcare workers become gatekeepers of the healthcare system and people seeking care find themselves in a disempowered position. Instead of working with people, as healthcare workers we were closing our doors (and therefore our eyes) to what was happening to the people we attended to, trying to control what were perceived as inadequate demands."

Interview with a general practitioner (2013).

"The waiting room is packed, as it is always. It is difficult not to recognise familiar faces, people from the neighbourhood. Sometimes, when you feel nervous about your appointment, meeting someone you know is a blessing because you can chat a little bit until the doctor opens the consulting room door and reads your name from the list. She greets us with her head because she knows some of us from a long time ago. I am lucky because my doctor does not get nervous when I ask her several things and we need to take more time than she expected. Other neighbours say that they can only spend five minutes with their doctor. [...] The PHC centre is one of those places where you feel safe in the neighbourhood. Some time ago we were closer to the healthcare workers, we were more connected: we researched together about the neighbourhood's housing conditions, about people's working conditions, about unemployment... Still, some days ago one neighbour told me that her doctor mentioned they were thinking about conducting new research together with the neighbourhood. There is a new group of young women (doctors) who want us to join them and think about the research. I hope they have time to do it before they are displaced again to another PHC centre."

"Centro de salud", in: Carabancheleando (eds.): *Diccionario de las periferias: métodos y saberes autónomos desde los barrios*, Madrid: Traficantes de Sueños (2017), pp. 71–73. Authors' translation.

Despite the enthusiasm of the first generations of general practitioners and nurses who contributed to building a PHC network rooted in the territories where they worked and organised as multi-disciplinary teams, the family and community speciality remains one of the least attractive for junior doctors. Even a big percentage of those who finish their training as family doctors choose not to work in PHC. The data is alarming: in 2018, just 13% of the general practitioners working in Spain were less than forty years old, so we do not know where the 19'000 family doctors trained in the last ten years are. What we do know is that they are not

working in PHC. Despite this far-from-ideal scenario, in 2013 people still trusted the public PHC system. Some people had better experiences with their PHC professionals, others had worse, but the PHC was still somehow considered the trustworthy base of the public healthcare system.

RUPTURE & REPARATION Rupture

"One of my hardest memories from that time was an evening in the Emergency Room, where there was not enough space for all the sick patients who came in. There were so many patients that there weren't any spare beds, stretchers, or even chairs, so the patients were sitting on the floor - waiting next to their oxygen bottles."

Interview with a general practitioner who worked as a junior doctor at the emergency room during the first months of the pandemic (2022). Authors' translation.

The first months of the pandemic were a period of self-organisation for both PHC centres and communities. Due to the lockdown measures imposed by the public health emergency, PHC restricted face-to-face care to specific cases, while most of the care was provided remotely, mainly by phone. Similarly, to avoid interpersonal contact, health centres were ordered not to participate in community interventions. Still, PHC professionals had some autonomy and managed to organise themselves to adapt to the changing reality, remaining united, supporting each other and seeking adaptations as a team to be able to continue attending to the population in the new scenario. During those same first weeks of the Lockdown, dozens of neighbourhoods created mutual aid groups independent of the healthcare centres.

As time passed, the distance between the PHC centres (the inside) and the population (the outside) widened.

While the mutual aid groups were struggling to cope with the growing needs of an increasingly vulnerable population, they could only see the closed door of the PHC centre and the difficulty of reaching their healthcare professionals by phone. What they could not see from the outside was that, inside those centres that seemed empty, their healthcare professionals were working harder than ever trying to respond to most of the phone calls. The gap between the PHC and the populations they worked with widened during that time of isolation.



Conversation between Adrián Carrasco and Estrella Sánchez, conducted on 13 September 2022. VIDEO ▸cache.ch/1705

The rupture, sharing feelings around a cup of tea.



Photograph by Adrián Carrasco (2020).

"One of the moments I remember the most was seeing the empty waiting room on my way out of the (healthcare) centre. It was impressive because although we never stopped working, we could not see the people we were working for, and giving advice to [...] Sometime later, the message that we were not working was spread, and it was because all our work was being done over the phone. Many patients were calling and nobody answered because we could not cope. Others wanted to come and see us but they were not allowed to enter the building."

Interview with a general practitioner who worked at PHC during the first months of the pandemic (2022). Authors' translation.

During the first months and the following ones, we were working hard while trying to protect ourselves from getting sick (despite the widespread lack of protection equipment). We had never worked harder, with so much stress, and doing so many extra hours, all while ultimately not being able to reach everyone who attempted to contact us. We had to cover for colleagues who got sick and who, in most instances, were not replaced. We even had to deal with the death of some colleagues. We also saw the increasing paperwork piling up on our desks: sick leaves, drug prescriptions, referral reports to A&E, etcetera. But while all this was happening, the waiting rooms remained empty.

We provided care through phone calls, but we lost in-person contact with our patients. It felt as if we were alone in a little fortress.

When patients tried to come to the PHC centre, they were stopped at the entrance and after being triaged were rarely allowed in. When patients tried to call, there were not enough people to answer all the calls, so many of these calls were unattended or received a delayed answer. Despite these access difficulties, PHC centres kept on being the most frequented facilities of the overall healthcare system, which shows that, to some extent, people kept on trusting the PHC system. Moreover, people showed their support in different ways, from daily public applause to more personal gestures of care.



Photograph by Adrián Carrasco (2020).

The COVID-19 pandemic increased paperwork to an unprecedented level.

As we explained previously, the historical lack of resources in PHC worsened during the pandemic, so when people felt sick and worried, they found it harder to be treated by their PHC professionals. Some people got the impression that the PHC centres were closed and even that PHC professionals were not working at all, even though we were working harder than ever. After the first wave, when our PHC centres started reopening to provide face-to-face care, the damage came to light: the pandemic had depleted the scarce resources of our PHC centres while increasing the healthcare needs of a population that had been left either unattended or not properly cared for. New administrative tasks (like processing paperwork for quarantine) took a significant amount of our limited time. More and more people shared the impression that the PHC centres were closed and that healthcare professionals were neglecting their patients. Somehow, we felt that while at the beginning there was some recognition and trust from the population, after the first wave distrust spread.

"The pandemic has also brought out the distance between the PHC centres and the population. People have their problems, and we are not able to solve them. This has happened before, but now it is even worse."

Estrella S.-Gamborino, a general practitioner (2022). Author's translation.

Overall, the pandemic has deeply affected the PHC teams. It has caused some colleagues to resign because they were exhausted and frustrated due to the increasing feeling of incompetence they had while working in such a dysfunctional system. They had to run away to protect themselves from greater threats to mental and physical health. Some of them did so publicly as a means of protest. As a result of the chronic underfunding and lack of physicians, to which resignations, sick leaves, and early retirements were added, those remaining professionals in PHC felt even more overwhelmed by the amount of work.

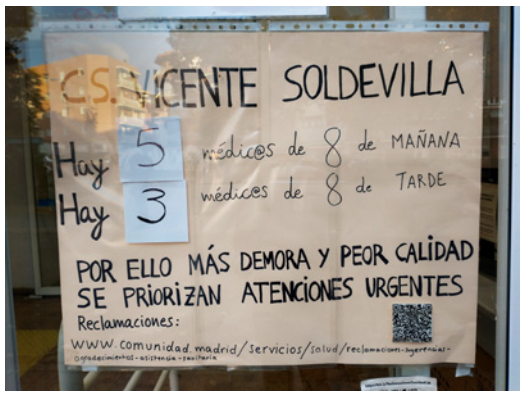
"Yo Renuncio, a PHC professionals collective invites you to join our COLLECTIVE JOB POSITION RESIGNATION as a means of protest due to its outstanding deterioration."

X (formerly Twitter)-Tweet from @ApRenuncio (1 October 2020), since deleted. Authors' translation.

"Today is my last day in a practice as a family physician in PHC. I quit."

X (formerly Twitter)-Tweet from @iguqui (29 December 2021). Authors' translation.

The public administration failed to replace those who resigned and to support the collapsing medical teams. In 2020, posters alerting people about the lack of doctors in PHC became a common practice. The posters, made by healthcare workers, informed people about the possible delays and the loss of quality of care while encouraging complaints to the regional government via the displayed link. Years later, this situation has not been solved, and many PHC centres still lack professionals. However, the lack of medical professionals is not evenly distributed. PHC centres located in socially deprived neighbourhoods lack more physicians than those in affluent neighbourhoods, which is a clear example of how the inverse care law works. Furthermore, in Madrid in 2021, only 21 of the 128 jobs offered in PHC were accepted, as these jobs are still not attractive for most of the brand new specialists in family and communitarian medicine. We are concerned about the impact that the personnel shortage may have on the wellbeing of those professionals that keep on working under those dire conditions, but above all we are concerned about how this increases the barriers for citizens to access good PHC.



Photograph by Berta Herranz (2021).

The flyer at the entrance door of the PHC centre *Vicente Soldevilla*, in Vallecas, Madrid, 2020 says: "Health centre Vicente Soldevilla. There are 5 doctors out of 8 in the morning shift. There are 3 doctors out of 8 in the afternoon shift. Therefore there is a delay and worsened quality. Emergencies are a priority". Authors' translation.

"When a physician or a nurse gets sick, there is no replacement, so their work has to be distributed among the rest. This is normally hard, but during the pandemic medical practitioners could get sick or burn out with all that extra workload. Some people couldn't take it anymore and had to say 'enough'. That's why there are so many centres with no doctors in the afternoon. And unfortunately this happens more in the underprivileged neighbourhoods. The Government was not able to find replacements to replace sick professionals, so their colleagues had to do more work, hence arriving at the same situation. It is like a snake biting its own tail."

Adrián Carrasco and Estrella S.-Gamborino, both general practitioners (2020).

RUPTURE & REPARATION Community Care

While PHC centres and professionals lost contact with patients, the community started to organise itself to share mutual care between neighbours and families. Some of us participated in these activities and witnessed how, as the production system was switched off, the care system was switched on: a peer-to-peer support system based on proximity and selfless help was working full time.

As many people were unable to go to work, they stayed home and provided mutual care in their communities. These caring communities mobilised to provide people with the daily living support they needed.

For example, they helped other neighbours to get some food, they organised child or pet care, they were on alert in case someone didn't communicate frequently enough, they acted as translators 24 hours a day, they drove their sick or dependent neighbours to a health centre or a hospital, etcetera. While problems with the health exclusion of migrants with and without residence permits persisted, these neighbours also managed to maintain certain access to the health system, connecting people's needs to the health workers inside the PHC centres. This caused a well-meaning envy in some healthcare workers who tried to re-connect or keep connected to the neighbourhood's networks. So, although healthcare workers were not allowed to participate in community-based activities, PHC professionals who were previously involved in these networks kept using them to adequately reach their patients' needs in such a complex situation. However, these networks were not a place to envy. People who supported and cared for each other did so at great cost.

"We were working from home, taking care of family members, and delivering food and other products to neighbours. On top of the fear of the virus, there were these mixed feelings of not having enough time to do it all, not having the opportunity to come together and think things through, and anger at public workers who referred people to the networks without contributing any kind of resources to them."

Interview with a participant in a support group during the pandemic (2020). Authors' translation.

"Where were the healthcare professionals, where were the public officers, where were the social workers, where was everyone that used to be physically present and holding responsibility for the common care? Even if they were working, they were not there, they were behind their closed doors."

Interview with a participant in a support group in Lavapiés during the pandemic (2020). Authors' translation.

Many people were also facing economic struggles and were themselves beneficiaries of already existing or newly improvised foodbanks. For example, in the Lavapiés neighbourhood, located in the city centre, a team of volunteer translators from Bangla and Senegalese communities, together with other members of *Red Interlavapiés*, visited households to explain general protection measures and to translate public officers' and healthcare professionals' epidemiological and clinical indications. These same people spent hundreds of euros on phone calls and text messages to promote vaccination among their communities, to reduce accessibility barriers, and to help mitigate doubts and fears.

"I spent the first weeks of the pandemic making calls to PHC centres. We wanted to figure out what they were doing with people without a healthcare card. Some people were being referred to mutual support groups by healthcare professionals, some were being denied care or threatened with being charged for it. The fear and the feeling of abandonment was huge. I myself, having been involved in the struggle for universal healthcare since 2012, could not believe some of the things I heard. The exhaustion being felt inside PHC centres in many cases turned into rejecting those who were in more vulnerable situations. It was the first time in nearly a decade that we had to go to court so a young woman could be treated for her illness, given the hospital's denial of her care. But we were also able to unlock situations of exclusion by explaining what the 'outside' situation was to professionals: 'yes, it is raining inside the healthcare centre, but there is a flood here outside'."

Marta Pérez, a participant in the social movement for universal healthcare (2020).

"Are we all more alone in our difficulties? Which is the real support that we can receive from our public institutions, and particularly from PHC centres? Are we entitled to also care and support those struggling inside PHC centres, who are also not being cared for enough by their own institutions? To what extent? How can we cope with it all? Where do we regain dialogue and common sense? How can we make sense of these developments?"

Interview with a participant in a support group during the pandemic (2020). Authors' translation.

These questions about how to take on the contradiction of doing public professionals' work were also shared in a mutual support network in Vallecas, a neighbourhood in the south of Madrid, called *Somos Tribu* (*We are Tribe*). The experience of the people working against healthcare exclusion can also testify to the impact of the pandemic closure of the healthcare system. The pandemic experience of having to assume the care of oneself and others without public support still persists in people's lives, especially for those in the most vulnerable positions. It raises the question of deservingness, which has been discussed previously in healthcare, especially regarding undocumented people. Today, the possibility of shutting down care for all has deepened.

RUPTURE & REPARATION Repair

In these final paragraphs, we offer some ways to begin a reparation. All of them come from formal and informal meetings with our wider network of friends and colleagues involved in community healthcare in which we have discussed how to talk about our concerns. Our experience tells us that we are on our own, with our own endless list of patients to attend to and our own despair while trying to reach our PHC physicians. How can we escape from it? How to talk about all this with others and, in doing so, identify commonalities, differences, and links between inside and outside concerns? How can we think from the threshold, together? In sum, how to politicise the pain and the rage but also the impotence and fear we feel towards the past, present, and future? If we - both professionals and the public - share a common loss of the sense and value of PHC, could it be that this sense and this value have been expropriated from us? Could it be that the conditions to create, construct, and nurture this sense and this value are not there anymore? How can we re-appropriate these conditions, and how can we create new ones, to produce a new sense and a new value? Time - or more precisely, the experience of both lacking time and feeling time accelerating - is one of our most pressing issues. Interrupting this relationship with time could be a way to open up possibilities for new presents and futures. What could happen if professionals and patients of a PHC centre came together, liberating two hours of consultation time to dedicate them to gather in an assembly? Would that be enough of a break for us to think together and share our experiences of the rupture from both sides?

"I write this text two weeks before I go back to clinical practice, it is a very timely reflection. Two years ago, I felt my professional world was breaking apart, and I was not able to make sense of my clinical practice. I stopped. I cherish my profession and I did not want to burn out completely. I took my time: I mourned the lost hopes and projects, I stood together with other friends and colleagues who were feeling the same way, and together we tried to reconstruct a valuable PHC. I am going back to clinical practice, and the rupture feels more like an Interruption: the initial burst that made me stop and take time out now feels like a burst between an interrupted past and an uncertain present. I hope the time I took helps me to maintain an interruptive attitude – to interrupt the individualistic logics that split us apart, the administrative nonsense that widens the gap between public and professionals, the overwhelming feeling of impotence."

Interview with a general practitioner who resigned in October 2020. Authors' translation.

Some of us working inside healthcare centres think common assemblies might help to shake up the exhaustion and lack of imagination that daily work in our current PHC brings. In our discussions, this little change immediately opened up our minds to possibilities for connecting grassroots movements to institutional work around health and wellbeing: to have free time and space not filled with programmed tasks, to let things happen, and to let ourselves value that indeterminacy as a health practice. Those on the outside think these spaces might provide meaning by enabling us to see that health workers show up, that they stand with the community, that they are there for us, and that our needs are heard and taken into account - within their limits, we know. Such spaces show us that we do not need to face things alone and that there might be things to think about and to do as a team. Physicians and patients share the core values of protecting our health and nurturing our right to care for each other. However, the institutional support for this is minimal: if they take place at all, these discussions are corseted into programmed groups about health education. Health workers themselves do not share the same need to create these spaces. In many PHC centres there is not even a team anymore, just a group of individuals trying to survive their daily work, with little sharing and common practice. Many are still hurting, angry, burned out. Still, as we finalize this text, PHC physicians in Madrid are on strike claiming for better working conditions to be able take better care of their patients.

It is a great task to repair these ruptured teams while agendas are full, patients suffer long waiting lists, and their health needs have been partially neglected or superficially addressed over the last few years.

How can we open new paths where even the mere thought of adding more work is unbearable? How can we gain a common sense from the inside? How to create and nurture time and space with the public outside while giving the best care possible to all our patients? How can we care for ourselves and recover the joy of creating new possibilities for better care and stronger relationships with our patients in our day-to-day? We do not have answers to many of these questions, and we know that interventions at different levels are necessary. But we intend to start where common people do things on an everyday basis, where the life of neighbourhoods and their PHC centres meet.

Notes

1 The authors would like to thank Irene Rodriguez Newey, Paloma Quintana and Peter McAndrew for their valuable contributions to the English editing of the text.

2 Janina Kehr: "Against Sick States: Ebola Protests in Austerity Spain", in: *Somatosphere: Science, Medicine, and Anthropology*, www.somatosphere.net (2014).

3 World Health Organization, Regional Office for Europe: "Declaration of Alma-Ata" (1978), https://www.who.int/publications/i/item/WHO-EURO-1978-3938-43697-61471.