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Medical specialty in México: 'here character is forged'

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ABSTRACT. The training of resident doctors in Mexico has been the subject of multiple studies that explore educational and learning aspects, as well as sociodemographic characteristics of these residents. However, the experiential reality of this training has not been explored. This qualitative study aims to analyze the discourses regarding medical specialization in Mexico through interviews with resident doctors, using Social Representations as a methodology. A semi-structured interview based on 6 analytical categories was conducted with 70 resident doctors from various medical specialties. The discourses obtained were analyzed using Atlas Ti V7 software. The common perception of being a resident doctor is characterized by being a slave and captive of a hospital, experiencing job precariousness, unequal treatment, physical and verbal violence, inadequate areas for rest and food consumption, and an uncertain future. The prevailing common perception among this group in training is that it involves domination, job precariousness, flexibility, and labor slavery... 'this is how character is forged here'... forming part of a hidden curriculum and an institutionalized and institutionalizing habitus of violence within the medical profession.

Keywords: Social representations; specialists; practicing physician; study program; profession.

Especialidad médica en México: 'aquí se forja el carácter'

RESUMEN. La formación de médicos/as residentes en México, ha sido objeto de múltiples estudios, que exploran ámbitos educativos, de aprendizaje y características sociodemográficas de estos, pero no se explora la realidad vivencial de esta formación. Analizar a través de las Representaciones Sociales los discursos en relación con la especialidad médica en México, a través de médicos/as residentes en formación. Metodología. Estudio Cualitativo, basado en una entrevista semiestructurada basada en 6 categorías analíticas: Se aplicó a 70 médicas residentes de diferentes especialidades médicas, los discursos fueron analizados con Atlas Ti V7. El sentido común en relación con ser médica residente, está referido como ser esclavo y cautivo de un hospital, con precarización laboral, tratos desiguales, así como la violencia física y verbal son parte de esta formación, además de áreas inadecuadas para el descanso y el consumo de alimentos, donde el futuro se marca como incierto. El sentido común predominante de un colectivo en formación transita entre la dominación, la precarizado, la flexibilización y esclavitud laboral... 'es así que aquí se forja el carácter' ...formando parte de un currículo oculto y un habitus de violencia institucionalizado e institucionalizante del profesional de la medicina.

Palavras clave: representaciones sociales; especialistas; médico praticante; programa de estúdios; profesión.

Especialidade médica no México: 'aqui se forja o caráter'

RESUMO. A formação de médicos residentes no México tem sido objeto de múltiplos estudos, que exploram ambientes educativos e de aprendizagem e suas características sociodemográficas, mas a realidade vivencial desta formação não é explorada. Mirar. Analisar através das Representações Sociais os discursos em relação à especialidade médica no México, por meio de médicos residentes em formação. Estudo qualitativo, baseado em entrevista semi-estruturada com base em 6 categorias analíticas: Foi aplicado a 70 médicos residentes de diferentes especialidades médicas, os discursos foram analisados com Atlas Ti V7. O bom senso em relação a ser médico residente é referido como escravo e cativo de hospital, precarização do trabalho, tratamento desigual, violência física e verbal fazem parte dessa formação, além de áreas inadequadas para descanso e consumo de alimentos, onde o futuro é marcado como incerto. conclusões. O senso comum predominante de um coletivo em formação transita entre a dominação, a precariedade, a flexibilidade e a escravidão do trabalho... 'aqui se forja o caráter' ...fazendo parte de um currículo oculto e de um habitus de violência institucionalizada e institucionalizante do profissional de medicina.

Palavras-chave: Representações sociais; especialistas; médico; programa de estudos; profissão.

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Introduction

Medical specialization is a technical-scientific process of continuous education of singular importance for the medical professional, as it plays a crucial role within the National Health System in addressing the population's healthcare needs. Throughout this postgraduate training, competencies are acquired through updated academic programs taught by competent instructors, enabling significant learning experiences (Fajardo, Santacruz, & Lavalle, 2015). Admission to the medical specialization program in Mexico involves the National Examination for Medical Residency Applicants (ENARM) administered by the Interinstitutional Commission for the Training of Human Resources for Health (CIFRHS, 2022), which serves as an interinstitutional collegiate body for consultation, advice, and technical support to the Ministry of Public Education and the Ministry of Health. After passing the examination, candidates are accepted by healthcare institutions that offer positions in their chosen specialty. Medical residents (postgraduate doctors) are not only important for future formation, but also represent a workforce. As licensed doctors, they have the authority to practice their profession, contributing to the active workforce in many of the hospitals where they are being trained. According to the figures provided by CIFRHS in 2021, there were 17,520 specialty positions available for nationals and 420 for foreigners, with a total of 42,580 applicants rejected (Table 1). It should be noted that the number of accepted applicants has significantly increased in the past two years, coinciding with the change of government, which has become a key point in the National Public Security Strategy to guarantee employment, education, health, and well-being through the creation of job opportunities and the fulfillment of every young person's right to higher education in the country, as well as investment in infrastructure and healthcare services (Mexico, 2019). While the number of professionals for specialization has increased, the number of rejections has also risen.

The National Health System has 81 specialty courses, and according to the Organization for Economic Cooperation and Development (OECD) in 2019, out of the total number of medical professionals in Mexico, 26% were general practitioners, 10% were non-specialist doctors working in hospitals, and recently graduated doctors who had not started their postgraduate training. Lastly, 64% were specialists, figures close to the recommendations of the OECD itself (2019) (23% general practitioners, 8% other doctors, 65% specialists). Regarding this last point, the current Secretary of Health, Jorge Alcocer Varela, reported that according to data from the Ministry of Health in 2022, there were a total of 135,046 certified specialists in Mexico, equivalent to 107.2 per 100,000 inhabitants, while the recommendation is 230 per 100,000 inhabitants. The largest number of specialists is concentrated in Mexico City, Nuevo León, and Jalisco, while Chiapas, Guerrero, Tlaxcala, and Oaxaca have the fewest number of these professionals (Jasso, 2022). This indicates a concentration of specialist professionals in major cities, while states with higher poverty rates and limited access to healthcare systems have fewer doctors and a scarcity of specialists. The process of specialization entails a significant workload, academic requirements, and personal challenges, which can impact the de-formation of doctors when the demands become even greater. An example of these effects is professional burnout in its different degrees, due to the implications of being a full-time resident with a dual role (Tafoya et al., 2020; Mendoza, Rodriguez, Yamal, & Duarte, 2021; Mendoza, 2020). Other perceptions explored among resident doctors revolve around deficiencies in the quality of their training programs (Dionisio, Ferreira, Molinas, & Espíndola, 2014), negative influencing factors such as the poor attitude of attending physicians, lack of availability for teaching, and poor interpersonal relationships (Martínez-Hernández, Esclante-Magaña, & Vargas-Mena, 2014; Miní et al., 2015; Peres-Romero, Caso, Vicente, & Cerezuela, 2012). These situations even worsened during the pandemic, where tasks related to COVID-19 did not contribute to the training plan (Orosa, Garcia, Ledott, Serrano, & Valero, 2021; Marttinéz et al., 2022; Alvarado-Socarras & Manrique-Hernández, 2022). These manifestations are fragments of common sense that are susceptible to exploration and analysis since they involve a collective in a formative process that simultaneously structures and reproduces patterns of behavior and generational meanings, creating highly structured social representations that can normalize forms of domination and the hidden curriculum. Therefore, the objective of this work is to interpret and analyze social representations in relation to the process of medical specialization, prioritizing the perspective of the "other" to identify critical issues that should be discussed in the training processes of future medical specialists.

Table 1. Resident doctors by specialty and their numbers.

Year	2016		2017		2018		2019		2020		2021	
Nationality	Mex	Ext	Mex	Ext	Mex	Ext	Mex	Ext	Mex	Ext	Mex	Ext
Specialty												
Pathological anatomy	66	10	75	18	80	18	83	19	222	18	179	15
Anesthesiology	773	55	863	67	880	63	942	67	1683	71	1738	54
Audiology, otoneurology, and phoniatrics	25	2	27	2	28	4	25	2	34	2	38	2
Quality of care	7	1	7	0	20	1	19	4	28	6	35	1
General surgery	670	51	743	57	762	47	889	51	1646	86	1851	40
Epidemiology	42	2	42	2	50	2	57	3	263	13	209	3
Medical genetics	25	7	29	7	29	7	29	5	38	7	45	5
Geriatrics	86	7	139	4	117	4	132	6	595	17	385	8
Gynecology and obstetrics	698	38	698	43	696	43	716	44	1285	96	1330	43
Diagnostic therapeutic imaging	303	38	286	47	286	49	333	44	531	52	570	38
Sports and exercise medicine	7	1	7	1	8	1	8	2	15	3	12	2
Rehabilitation medicine	79	15	103	14	97	12	107	6	449	9	271	5
Emergency medicine	615	17	620	21	610	22	826	17	1962	70	2230	17
Occupational and environmental medicine	55	4	44	4	85	2	94	1	115	1	174	1
Family medicine	1636	12	1659	13	1675	13	2073	7	3582	27	2717	9
Integrated medicine	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
Internal medicine	1047	60	1126	66	1133	53	1281	60	2142	105	2275	51
Forensic medicine	7	0	7	0	7	0	7	0	5	0	NO	NO
Nuclear medicine	14	8	16	5	13	5	13	3	14	3	23	2
Preventive medicine	9	3	10	3	10	3	10	3	12	3	12	3
Pulmonology	59	8	55	9	46	9	45	9	145	14	192	5
Ophthalmology	155	15	179	18	179	17	213	18	271	22	321	15
Otorhinolaryngology and head and neck surgery	87	13	89	15	87	15	96	12	159	18	143	7
Clinical pathology	25	2	20	0	24	2	30	3	43	3	58	2
Pediatrics	770	56	772	56	798	54	806	54	1381	88	1359	50
Psychiatry	156	17	173	18	164	16	165	15	341	21	305	16
Radiation oncology	72	1	34	1	31	3	25	2	50	5	36	3
Public health	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	V
Traumatology and orthopedics	319	26	440	33	418	23	456	27	889	53	1012	23
Total accepted	7810	467	8263	524	8333	488	9480	484	17910	813	17520	420
Rejected	28304		30117		33090		33200		27290		42580	

Source: Own compilation with data obtained from the XLV National Examination for Medical Residency Applicants 2021 (2022).

Methodology

Our methodological approach is based on an analysis of social representations [SR], referring to the theory developed by Moscovici in the mid-20th century. The purpose of this theory was to redefine the problems faced by contemporary societies, where socialization allows for the construction of common knowledge, expressions, conceptions, and notions of life that accumulate in communal memory, creating a shared memory that can be studied and analyzed. From this perspective, it becomes important to study how individuals construct and reconstruct their social reality (Moscovici, 1979).

This is a cross-sectional phenomenological qualitative study. The sample was obtained through non-probabilistic sampling and consisted of 70 resident doctors from different medical specialties [family medicine, general surgery, pediatrics, physical medicine and rehabilitation, gynecology and obstetrics, traumatology and orthopedics, ophthalmology] from the following institutions: Mexican Institute of Social Security (IMSS), Institute of Social Security and Services for State Workers (ISSSTE), and Institute of Social Security of the State of Mexico and Municipalities (ISSEMYN). All participants agreed to participate after giving informed consent. The study used the structural approach of social representations based on Abric's model (2001), and the methodology included the following steps:

1) The first phase consisted of a micro-ethnographic approach to the active space (hospitals).
2) The second phase involved working with a focus group of 10 resident doctors, conducting a brainstorming session (phrases, words, expressions) with the trigger phrase: "What does medical residency represent to you?"
3) Subsequently, the words, phrases, and expressions that appeared most frequently in the discourse were identified, and analytical categories were generated. The analytical categories obtained were: a) being a resident, b) activities, c) power dynamics and domination, d) norms and values, e) the hospital training process, and f) the future of the specialty.
4) With these categories as a framework, a question bank was created to generate a semi-structured interview. The interview was subjected to consensus by experts from five disciplines [Public Health, Collective Health, Social Psychology, Medical Anthropology, and Medical Education]. Using the Delphi method, a final instrument consisting of 30 items was developed, establishing construct validity. Content validity was assessed by conducting the interview with a pilot group of 5 resident doctors.
5) Audio-recorded interviews were conducted with 70 resident doctors, ensuring informed consent and maintaining anonymity. The interviews were conducted between January 2021 and January 2022.
6) Data analysis was performed using the Atlas.ti software. Phrases corresponding to the analysis categories were selected. Descriptions that did not align with the interview objectives were eliminated, and codes were created for each interviewee. Triangulation was conducted through theoretical comparison and by multiple researchers. The project was registered and approved by the "Bioethics Committee of the SACSIC Network".

Results

Out of the interviewed group of doctors (N=70), 51 were female and 19 were male. The average age was 32 years (SD = 4 years). Regarding marital status, 31 were married, 24 were single, 12 were divorced, and 3 were widowed. 100% of the participants were fully dedicated to their specialization studies.

In terms of discursive interpretation, it is appropriate to present the findings according to the pre-established analysis categories. These categories can be understood as the central thematic cores of the structure and function of the social representations in this research, allowing for the interpretation of these representations to take place.

a) Being a resident

In this category, we understand identity construction as defined through the relationship from the collective in relation to the "other" or something, exclusively based on lived characteristics (attributed by cultural interaction) such as gender, race, religion, etc.

Being a Resident means being "...a slave (E3)...being captive in the hospital (E8)...being subjected (E19)...having no voice or vote (E43)...being submissive (E47)...not complaining (E48)...receiving reprimands (E50)...learning to follow orders (E56)...being a necessary step to practice in the specialty (E59)...here you learn responsibility, dedication, sacrifice (E65)...social prestige (E28)...self-improvement (E32, E35, E42)...to have a job (E62)...continuing to prepare for the future...being a better doctor... 'character is forged here' (E15)...".

Through these discourses of identity, we perceive that these individuals find themselves in dominant, violent, and stigmatizing environments, where encounters among peers become conflict-ridden situations. This is driven by structural submission in healthcare, where management dictates adherence to protocols and administrative instructions, leading to a submission based on a thin line between Being a Resident and being a worker or trainee.

Taking into consideration the provisions of articles 94 and 95 of the General Health Law (1984), a medical resident is, as the name suggests, a physician. They hold a university degree and professional license, which are the legal requirements in Mexico to practice general medicine in any public or private healthcare institution. This grants them the authority to take care of patients, prescribe medications, and assume legal, moral, and professional responsibility for the health of individuals and the population. According to the Federal Labor Law (2015), a medical resident occupies a provisional position within an institution or hospital unit, based on their current title and professional license as a general physician. Lastly, the Official Mexican Standard NOM-001-SSA3-2012, Health Education, for the organization and operation of medical residencies, includes complementary clinical activities, also known as shifts or on-call duties, as part of the training period. The resident is, therefore, both a healthcare worker and a postgraduate student. On one hand, they are a general physician in a specific medical area, carrying out activities within the specialty service where

they are undergoing training. They have an immediate supervisor who is responsible for the respective service, and they have an employment contract that ends when their training is completed. On the other hand, they are also a postgraduate student, guided by a mentor who oversees their clinical, teaching, and research activities specific to the specialty in which they are training. In summary, they are a multifunctional and multifaceted agent.

Moreover, there is the ruling on Contradiction of Jurisprudence 308/2016 (Federal Judicial Power. Supreme Court of Justice of the Nation, 2016), which states that "[...] the medical resident is a student with a labor character [...]," granting them union rights, institutional seniority, and legally mandated benefits. With this ruling, optimal conditions can be sought for educational quality, creating a friendly learning environment with work and educational schedules aligned with those of attending physicians. It also includes the provision of healthy spaces for rest, mealtime, or recreation, as well as aligning salaries with those of attending physicians. This will contribute to generating educational and formative changes, as well as economic stability for medical residents.

These discourses shed light on the aspirational condition surrounding the pursuit of social recognition and status based on a professionalization that is conditioned by the commodification of healthcare, accepted as part of a cultural tradition of being a medical resident – "character is forged here." Paradoxically, in relation to the Sustainable Development Goals 2030 concerning health, which refer to increasing health financing, hiring, development, training, and retention of healthcare personnel in developing countries, specialization becomes a motivation for general physicians to obtain a better salary.

b) Activity

This category characterizes the role of the subject in the process of interaction with an object, as well as the individual's modes of relating to their external world, denoting meaning. Regarding the most representative discourses, we find the following:

> [...] excessive workload (E2) ...you do a lot of what the base doctor doesn't want to do, you do everything and don't even have time to eat (E14) ...sometimes you perform nursing procedures, whatever they tell you (E19) ...you do shifts, and if you make a mistake, you do more shifts, you learn through repetition (E22)... I start my activities early, and I don't have a set finishing time (E30) ...you have many obligations and no rights (E41) ...you have to do everything they ask, even act as a porter (E43)... you wake up, start with the notes, take samples, paperwork, you try to survive (E46) ...you work and work and study when you can (E49) ...attend to patients without complaints (E53) ...do a lot of practice (E60) ...provide support (E62) ...heal the patient (E65) ...diagnose, treat ailments, go into the operating room (E68) ...here, you endure and suffer because there's no one to help you (E70) [...].

The training of medical residents has been distorted since its inception. This human resource is used in an operational manner across different levels of healthcare in Mexico. Their presence becomes a forced necessity within the healthcare system because they are seen as a cheap and replaceable resource for healthcare provision. Their activities involve exhausting hours of work, with a labor schedule exceeding eight hours, without breaks or meal times, in addition to the extra hours of training shifts.

The discourses mentioned contradict what is stated in the Official Mexican Standard NOM-001-SSA3-2012 (Secretary of the Interior, 2013), which states that healthcare units receiving residents should have a dining area and rest area. However, it does not specify infrastructure requirements. Similarly, regarding shifts, it mentions that they should be scheduled according to the corresponding operational program to develop the academic program punctually, including the frequency, schedule, and duration with at least a two-day interval between each shift. Lastly, regarding the presence of a tutor, it states that this individual should coordinate and supervise the clinical, academic, and research activities, reinforcing the acquisition of skills useful for the application of acquired knowledge. This situation differs from the discourses expressed by the specialists in training, which indicate the lack of support in their training process. Following the NOM-001-SSA3-2012 (Secretary of the Interior, 2013), a Draft Standard PROY-NOM-001-SSA3-2018 (Secretary of the Interior, 2018) was developed for health education, regarding the organization and functioning of medical residencies in healthcare establishments. However, this draft has not gone through the necessary procedures to become official and therefore has never been in effect. Recently, on June 17, 2022, a new official Mexican standard for the organization and functioning of medical residencies was published in the Official Gazette of the Federation. The NOM-EM-001-SSA3-2022 (Secretary of the Interior, 2022) is an emergency standard, meaning it was published to prevent imminent harm or mitigate or eliminate existing harm. It mentions that the imminent harm is the lack of specialist doctors, and urgent changes are needed to make the training

process more efficient. This new standard does not include substantial substantive changes; it is very similar to its predecessors, with administrative, educational, legal, and rights-related gaps due to its ambiguity on issues such as working hours, abuses, sanctions, harassment, gender-based violence, discrimination, lack of classes, and so on. For example, the new standard mentions a collegiate body responsible for education, but it does not explain its functions. It also states that this body will be used for "serious offenses," where attending physicians and professors determine if an offense occurred and its punishment. However, it does not provide details on what constitutes a "serious offense," and nothing is mentioned about offenses committed by other participants in the system. Regarding shifts, the document mentions that there should now be three days between each shift, but it allows for schemes of every two days or even alternating days. This means that shifts of over 80 hours per week can be worked without any sanctions for the healthcare unit, as it is left to the discretion of the attending physician or service chief. This seems like a regression from the concerns and necessities expressed in the discourses.

c) Power and domination relationships

In this category, we will describe the discourses that reflect disparate or submissive relationships that contribute to the formation of group inequalities.

Here, we observe discourses such as "[...] the highest-ranking person is in charge here (E1)... the attending physician has the authority (E4)... the longer someone has been in the specialty, the more power they have (E8)... the chiefs are dictators, you have no say (E11)... the administrators do not listen to our needs (E14)... if you complain, you get fired (E17)... there is no room for complaints (E22)... when they vaccinated for COVID-19, first came the senior staff, and then those of lower rank (E25)... you have to endure sexual harassment (E28)... you tolerate workplace harassment (E31)... you endure physical violence in the operating room (E34)... we live with verbal and psychological violence (E37)... neither the union nor the university is present to defend you, there is no one (E40)... punishments and abuses continue (E42)... the hospital does not address our complaints (E46)... the university never responds to us (E49)... and even less so when it comes to harassment claims (E54)... we spent two years in the specialty without anyone addressing us by our names (E56)... here, there is no room for being sick, that doesn't exist (E59)... they complain about everything, they don't have the resilience they used to (E63)... they demand everything, only the strong and the best can endure in the specialty (E67)... we must understand that we are fellows, not workers (E69) [...].".

These discourses show us that the construction of domination and power is legitimized through conflict, the invisibilization of the other, and violent acts - both physical and verbal - as cultural practices, where discursive power is observed through the subjugation of the human resources in training. It is worth mentioning that there are no official figures or formal complaints regarding mistreatment and forms of violence that align with discourses of fear as a hegemonic cultural practice of refraining from complaints, perpetuating violent rituals that are passed on to others and among peers as part of learned social reproduction. Bullying and/or mobbing and burnout are part of this formative construction and the origin of one of the many forms of violence in the medical field (National Human Rights Commission [CNDH], 2017), contributing to health issues in this group such as suicide, alcoholism, and drug addiction, which are often overlooked (Bolivar, Milena, & Corredor, 2013; Alvarado-Socarras & Manrique-Hernández, 2019; Velázquez, 2018).

According to data from the Survey of Medical Trainees 2021, conducted by civil society organizations *Nosotrxs* and the *Colectivo de Médicos en Formación* with 2,458 participants across all 32 states of the country, 40.2% reported experiencing sexual harassment during their training activities, and 40.5% reported having suffered some form of mistreatment in the university and clinical settings (Vega, 2021). These figures are likely an underrepresentation of the manifestations and the environment of violence experienced by medical trainees, as many of these incidents occur and are perpetuated in traditional ways.

d) Norms and values

This category is distinguished by the significance of the standards that regulate behavior within the group in relation to what they aim to achieve or accomplish as a collective.

The obtained discourses refer to: "[...] respect for the patient (E1, E5, E7, E10, E15, E46, E57, E68) ... responsibility (E8, E18, E24, E37, E48, E59) ... politely greeting the patient (E16, E25) ... being cordial with the patient (E4, E11, E19, E26, E38) ... listening to the patient (E2, E13, E20, E23) ... commitment to the specialty (E9, E12, E22, E30) ... collaborating with the patient (E56, E70) ... honesty with the patient (E6, E31, E44) [...]".

These phrases speak of Medical Ethics established from the Hippocratic Code and reinforced under the principle of helping as a responsibility of the profession, as well as an implicit universal regulation observed in the Declaration of Geneva of 1948 (Herranz, 1985). These ethical principles permeate the training of medical professionals from undergraduate to postgraduate levels. Similarly, there is a reference to conducting oneself with respect towards the patient. Paradoxically, within the main reasons for complaints filed with the National Medical Arbitration Commission (CONAMED), complaints related to the doctor-patient relationship precede those related to medical treatment (Conamed, 2022). This may allude to the romanticized conception of the profession and its use as an ideological instrument to establish and maintain legitimacy with the idea of service above personal interest (Torres, Soto, & Patino, 2020). It is worth mentioning that there is no apparent presence of values and norms with institutional reference, which is essential for building an organizational culture (Cabrera, 2008). This lack of institutional values and norms hinders the establishment of a solidary and just core that promotes formative behaviors among medical residents. Furthermore, there is no mention of values and norms among peers, which leads us to question the situation of normalized violent behaviors towards fellow trainees (Caparó & Zúñiga, 2018). These acts persist despite awareness campaigns (NOM-001-SSA3-2012; Rojas, 2021; Molfino, 2022). Additionally, the lack of psychological support exacerbates the burden of repressed emotions during training.

e) The process of hospital training

This category refers to the educational elements that interact with the training of resident physicians. Here we find discourses regarding: "[...] there are no areas to rest (E1)... the residency is dirty, with a bad smell, and the beds are of poor quality (E2)... we don't fit in the on-call rooms to rest, I have to share the bathroom and shower with my colleagues (E4)... the hospital food is very bad (E5, E8, E11, E15, E19, E67)... the food tastes awful (E14) and is not balanced (E20)... the uniforms are terrible (E22)... the lab coat and shoes are of poor quality, and you are also forced to wear them (E25)... during the peak of the pandemic, I had to buy all my personal protective equipment (E29)... the payment or stipend is meager (E6, E27, E34, E35, E37, E43, E50, E53, E58, E60, E63, E7, E69)... it's not enough to live on (E44, E58)... considering everything we do, the stipend is a mockery (E51)... the trainings and educational activities are coordinated by us (E33)... there are no classes (E48)... if you need a training, you have to pay for it (E28)... here, you learn through practice (E7, E9, E12, E17, E24, E32)... there is no university authority that has approached the hospital (E9, E18, E26, E36)... we have to go to the university, and we don't have time (E43) [...]".

The elements that emerge from these discourses are three: facilities and services, stipend payment, and Educational Institutions. The discourses related to the first element refer to what is stated in the Official Mexican Standard NOM-001-SSA3-2012, which establishes in point 6.9: "[...] the medical units receiving residents must have a dining area, as well as a resting area for resident physicians on duty [...]". However, this document does not specify the characteristics of the resting areas, which are often overcrowded and in poor cleaning conditions. On the other hand, the food provided is far from being nutritious, which is an important aspect of human needs. Resident physicians do not have the necessary time and space for self-care.

Regarding the second element, it is noteworthy that the remuneration provided by healthcare institutions is insufficient to achieve a dignified life as a professional, which is consistent with data from the OECD indicating that Mexico has the lowest average salaries in the region for all healthcare personnel. The annual income of 21,343.99 dollars earned by these workers, regardless of whether they are employed in the private or public sector, represents nearly one-third of what is earned in Chile (Villanueva, 2020). Precariousness is not only economic; it is an emerging phenomenon linked to and binding with subjectivities and identities in the workplace, and in this case, also in academia.

Regarding the third element related to the receiving institution, the discourses refer to a lack of presence in the educational process and a lack of support in training, as the emphasis is placed more on labor functions rather than on teaching and training. Similarly, there is a perceived absence on the part of the university representation, which leads to ambiguity in roles and a loss of control over work (Acosta-Fernández, Aguilera-Velasco, Pozos-Radillo, Torres-López, & Osorio, 2016).

f) The future of specialization

Here we will compile the idealistic discourses regarding the anticipation and forecasting of the future based on the interests of medical specialists in their respective specialties.

> [...] this cannot continue like this, there must be other models of specialization (E2)... many friends are left without a specialty, and that is concerning (E11)... the ENARM exam should disappear, there should be another way to enter a specialty (E25)... the training model in medical specialties will become obsolete in the coming years (E38)... there is no future planning for the medical specialties that the country requires, Universities or the Government are not interested (E56)... future generations will no longer study medicine (E68)... there are no and there will not be medical specialists in the coming years (E62)... this is caused by the low salaries and mistreatment in the training of specialties (E43)... if the authorities do not address the current issues, candidates for a specialty will opt for other careers or trades (E37) [...]".

These discourses point us towards a prospective stance, as they are part of an exercise of identified perspectives within the core of the training process, where conflicts exist and can give rise to possible futures. Here, discursive proposals emerge that, when viewed from the training reality, represent pluralities that forecast what the future might ultimately look like (Barajas & Concheiro, 2015).

These prospective scenarios revolve around three key aspects: the admission process, the training phase, and the future destination. In the first aspect, it is argued that an admission exam is not the most effective way to identify the best candidates for a specialization. The current centralized admission process overseen by the CIFRHS (Inter-Institutional Committee for the Evaluation of Higher Education) has been subject to various corruption scandals. An alternative approach, similar to that implemented in the United States and New Zealand (Fajardo et al., 2015), would involve conducting state and federal-level assessments of healthcare needs and then offering residency positions to those interested, with flexible scheduling options. This would allow physicians to work in private or public healthcare settings while pursuing their specialization.

In the second aspect, the formation phase, conflicts arise within environments characterized by hidden curriculum, where cultural practices during training involve physical or verbal violence, academic absences, and intimidating atmospheres. These discourses call for a reevaluation of the culture of institutional relationships, such as the tutor-resident, resident-resident, resident-student, resident-other staff member dynamics, etc. The aim is to promote environments that democratize knowledge by fostering teamwork (Castro, 2012) and rehumanize the training and educational processes in order to humanize medical practices. This entails promoting healthy institutional relationships and creating a supportive and inclusive learning environment for residents (Jaramillo & Valentín, 2020).

Lastly, in the third aspect, there is a reference to an uncertain, discouraging, and disillusioning future, which has contributed to an increase in the abandonment of medical specialization. This is due to factors such as anxiety and obsessive traits that increase the risk of stress and burnout (Amorós et al., 2020), as well as suicidal ideation and completed suicide within the profession (Alvarado-Socarras & Manrique-Hernández, 2019). This can be observed when individuals are choosing their career paths, as new generations are opting for a future with a better quality of life (Chacaltana, Dema, & Ruiz, 2018), rather than a profession with so many academic, governmental, and financial constraints. Accordingly, this trend may lead to a gradual abandonment of the medical profession in the future.

Conclusion

This research allows us to glimpse a widely acknowledged reality, where technical, administrative, academic, and financial interests in healthcare play a role in arranging the pieces inappropriately, believing that the depicted reality is a utopia. Here, we find ourselves in a world where medical training is filled with discourses of domination and submission, where the sign of being a specialist doctor is to surpass oneself at the cost of forging one's character through precarity, flexibility, and labor exploitation. In this way, structural violence in healthcare is shaped to serve national interests at the expense of the profession, where the romantic notion of the profession is used to enforce the submission of these professionals.

Therefore, specialization itself is a form of cultural capital, according to Bourdieu, as it gives rise to the habitus of the specialist doctor, which, according to the discourses, is composed of a dominated, precarious, tired, frustrated, and uncertain worker, doctor, and student. It is a form of objectified cultural capital based on the attainment of an academic degree as a tool for capitalization and maintaining social status.

It is time for us to address many of the issues that torment this training and seek new alternatives. These alternatives should be part of an open dialogue among peers, rather than solely listening to the voice of the official discourse. Let us, as specialist doctors, strive for a better world for our profession.

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