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LETTER TO THE EDITOR

Medical residency, how friendly should it be? The clash of generations

La residencia médica, ¿qué tan amigable debe ser? El choque de generaciones

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«Physicians are martyrs to science and duty.»
Juan A. Matus (1859)

The so-called medical residency system began in the era of Dr. William Osler in Baltimore, United States, in the early 20th century at Johns Hopkins University. It was designed so that physicians would spend a period living in or near the hospital while completing their specialized clinical training.[1] The aim was to bring learning closer to everyday hospital practice. Direct immersion in the clinical and working environment was considered a useful educational tool for reinforcing the necessary training. The duration varied considerably depending on the specialty involved (surgery or medicine) or the particular field of study.

Because of this requirement to remain at the workplace, postgraduate programs in clinical training became known as “medical residencies.” This period provides trainees with countless rewarding experiences, but also with many bittersweet moments because of the complexity of the situations they encounter, including death, psychological pressure, academic workload, pain, illness, complaints, and workplace problems.

Throughout time, hospitals concluded that accommodating hundreds of postgraduate trainees living on or near hospital premises for extended periods (sometimes years, depending on the program) was costly, and this system gradually ceased to be promoted. Today, few hospitals continue to provide such accommodation to postgraduate trainees. The usual arrangement is for residents to attend their clinical duties and subsequently return to accommodation of their own choosing, independent of the hospital administration; only staff on duty are provided with basic accommodation during their shifts.

No one has ever claimed that medical residency is an easy process. Some programs are generally considered more demanding than others because trainees face complex situations in hospital practice, with responsibilities increasing year after year. This can be disconcerting for trainees, who abruptly leave behind the relative protection afforded by being undergraduate medical students and suddenly become responsible for an entire hospital ward, as well as for clinical care decisions during their corresponding on-call duties.

Working hours are long, opportunities for essential rest are limited, and the demands imposed by the medical situations encountered during these shifts are considerable. At the end of an on-call shift lasting at least 24 hours, and sometimes longer, residents often continue working in the department as though they had arrived from home on an ordinary day, with little consideration given to the fatigue accumulated during the preceding hours of work. Social media have now

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brought widespread attention to situations involving both individuals and groups who report systematic mistreatment of healthcare professionals in training. Their complaints most commonly concern a lack of respect for basic rights, mistreatment, insufficient time to sleep or eat, and inadequate academic training, among other issues.

Of note, medicine is easier to study (although studying it is already difficult) than to practice. The situations described above closely resemble those traditionally reported for decades both in our country and in other parts of the world. It should also be remembered that a physicians' movement known as the "White Movement" took place between 1964 and 1965 in an attempt to strengthen and defend the role of residents in hospitals, although unfortunately its achievements were limited.[2]

Several questions arise from this situation:

- What is the ideal medical residency system?
- Can and should all candidates undertake a medical residency?
- Do hospitals offering postgraduate programs have the facilities, infrastructure, and teaching staff required for this purpose?
- Are contemporary medicine and today's patients more accommodating toward physicians undergoing specialist training?

There may be many more questions, and there will undoubtedly be many possible answers. New generations of graduates invariably change the dynamics of social interaction. Practices that were once regarded as necessary for a person's training may now be considered abusive, and measures previously implemented as disciplinary actions are no longer tolerated.

Currently, there is a "generational clash" in medical training.[3] Nevertheless, patients continue to demand the best possible clinical care without delay, legal claims are increasing, hospital needs are seemingly unlimited, and budgets are being reduced. Society also appears to display a sense of "immortality," struggling to accept that life eventually comes to an end and persistently rejecting this possibility regardless of advanced age or the medical complications associated with a particular disease.

All these circumstances generate stress and dissatisfaction among everyone involved, making specialist residency training increasingly complex. Trainees therefore require certain personal characteristics, including determination, initiative, character, resilience, resolve, and many other attributes, in addition to scientific knowledge of their discipline. With appropriate academic mentors, however, these goals can be achieved.

Just as not every physician is suited to being a teacher, researcher, or administrator, regardless of how good a clinician they may be, not every medical student will necessarily be able to complete a medical residency successfully. However, those who do not pursue residency training can still explore an unlimited range of professional opportunities if they wish, including primary care, education, research, administration, and the pharmaceutical industry.

It would be very difficult, and potentially counterproductive, to reduce the level of rigor required in specialist medical training programs because professional practice itself demands a high standard. Nevertheless, from the standpoint of ethical and bioethical principles and respect for human dignity, teaching staff should receive professional training, and the psychological profiles of applicants should be assessed, particularly those entering specialties associated with intense professional demands and substantial emotional challenges, such as emergency medicine, intensive care, surgery, oncology, and trauma care. There is an enormous global shortage of medical specialists, and this deficit is expected to increase in the coming years. Training programs therefore need to be restructured, accompanied by an appropriate academic assessment of current and future healthcare needs, so that new candidates can select programs that best match their professional and personal expectations.

Perhaps we should reconsider the so-called "rotating residency" that existed in Mexico more than half a century ago. Under this system, newly graduated physicians spent 1 year rotating alongside residents and attending physicians through different departments, including internal medicine, surgery, gynecology, and pediatrics. They participated in clinical and academic activities as members of the team, albeit at a lower hierarchical level. This experience allowed them to make a better-informed choice regarding their subsequent professional career. Sometimes, looking to the past can provide the best answer for the future.

Not everything is lost. On the contrary, new forms of understanding are needed if progress is to be made in all areas, with particular emphasis on the shared responsibility of teachers and trainees in meeting this challenge. Planning for improvement is always worthwhile, as it will ultimately help ensure the best possible care for both present and future patients.

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