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Resistance to experiences of violence in medical residences.

Resistencias ante las experiencias de violencia en las residencias médicas.

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Abstract: Medical residencies guarantee the academic and human training and preparation of future specialists. However, aggression in the medical education environment seems to be an inherent part of their intra-hospital interactions during their training. If the medical student experiences and observes mistreatment in the relationship with his teachers and peers, he assimilates it as a form of behavior and domination. However, domination is rarely total, because in its exercise cracks appear, spaces that leave room for the deployment of micro-resistance strategies. The purpose of this work is to recognize the micro-resistances that arise among residents in response to acts of violence resulting from the highly hierarchical interactions they experience during their training as medical specialists. A qualitative study was carried out using the focus group technique. The results show four general dimensions: 1) abuse of power, 2) control mechanisms, 3) disregard for teaching and learning, and 4) gagging of complaints, which reflect the experiences of violence experienced by residents during their training. It is concluded that swiping, laughing, and keeping quiet were the residents' micro-resistances to the grievances they experienced, which were located in an energetic game of control in constant tension and contradiction; however, it allowed residents not to give up on residency and to continue on their path to becoming medical specialists.

Keywords: Medical residencies, violence, micro-resistance, medical education.

Abstract: Medical residencies endorse the academic and human training of future specialists. However, aggression within the medical education environment seems to be an inherent part of intrahospital interactions during training. If a medical trainee experiences and observes mistreatment in their relationships with professors and peers, they may internalize it as a behavioral norm and a form of domination. Yet, domination is rarely absolute, as cracks often appear, creating spaces for the implementation of micro-resistance strategies. The aim of this study is to identify the micro-resistances that emerge among residents in response to acts of violence stemming from the highly hierarchical interactions they encounter during their specialist training. A qualitative study was conducted using focus group techniques. The results revealed four general dimensions: 1) abuse of power, 2) control mechanisms, 3) disregard for teaching and learning, and 4) silencing of complaints, which highlight the experiences of residents with violence during their training. It is concluded that evading, laughing, and remaining silent were the micro-resistances used by the residents in response to the abuses they experienced. These strategies were situated within a dynamic and contradictory power struggle, which allowed the residents to persist in their residency and continue on the path to becoming specialist doctors.

Keywords: Medical residencies, violence, micro-resistances, medical education

1. Introduction

Medical residencies guarantee the academic and human training and preparation of future specialists. However, violence (understood as actions that threaten the physical or moral integrity of an individual) in the medical education environment seems to be an inherent part of intra-hospital interactions during training (1). In the medical field, it is conceived that a certain level of intimidation and humiliation in interactions during training are necessary to prepare the physician for a difficult profession (2) . These interactions are established in highly hierarchical structures that are effective mechanisms for carrying out complex tasks such as those that occur in health institutions (3). An element that determines hierarchical positions is the number of years that the resident has completed; those who have fewer years as students present the temporary role of being apprentices, seeking spaces for practice and learning during their care work, as well as feedback from those with a higher degree (4). These types of relationships are prone to developing into inequalities and abuse of power that give rise to violence. The main perpetrators of acts of violence against residents have been the same colleagues with higher hierarchies and basic physicians (5-6).

A study conducted in Mexico reports that 87% of specialists report at least one experience of violence in their medical training and up to 50.46% report having experienced psychological violence (1), whose adverse effects are much greater than those of physical violence, as consequences 89% report burnout, 71% depression, 78% anxiety and 58% poor patient care; the above interfere with and reduce learning (mainly in surgical specialties) (5); they also have consequences on mental health and the doctor-patient relationship (1, 7). Another type of violence that frequently manifests itself is academic violence such as punishment guards and denial of teaching. Prolonged and repeated exposure to violence creates a qualitative change that leads to various emotional disorders that result in low-quality medical services (5-6).

If residents in training experience and observe mistreatment in their relationships with their teachers and with higher-ranking physicians, they assimilate it as a way of behaving, of disciplining themselves, and of perpetuating the abuse of power. However, discipline is hardly total, because in its exercise cracks appear, spaces that leave room for the deployment of micro-resistance strategies (8) by residents that will be expressed in speeches, gestures and practices, visible or hidden for those who occupy positions of authority during their training process (9). For Foucault, power is diffuse and relational, where it is held there is also resistance, which is not always to destroy power, it is rather an attempt to escape from oppression (10). Scott speaks of the daily experiences of veiled micro-resistances, these are less organized forms of resistance, they can be hidden, outside the public scene; In these, expressions of indignation, anger and anecdotes of small rebellions appear and can give rise to alternative spaces where new forms of more horizontal relationships are built (8, 10). De Certeau focuses on practices and not on the consciousness or intentions of the dominated, he speaks of "tactics" as the ways in which subordinates take advantage of the loopholes in the system to alleviate their oppression (10).

Physicians learn the rules of how to act in order to become residents through the recognition of higher-ranking residents (11). However, lower-ranking students experience violence, and in the face of these acts, interrelations, communities, and alternative and dissident subjectivities are built in order to continue and not give up on the goal of becoming a specialist physician. The purpose of this work is to recognize the micro-resistances that arise among residents in response to acts of violence resulting from the highly hierarchical interactions they experience during their training as specialist physicians.

2. Method

In order to investigate the experiences of violence and the mechanisms of micro-resistance, which are established in a relational manner and are nourished by emotions, this qualitative study was approached with dynamic analysis tools, based on non-linear and interactive assumptions that offer a phenomenological and procedural vision of the way in which residents construct their vision of social reality (12). The manifestations of micro-resistance are generally not public, they are traced in practices and discursive modes, ideally in spaces outside the established power (10). The Focus Group (FG) technique was used, which allowed for an authentic and participatory group dialogue in a climate that fostered equitable participation, self-reflection and the capture of moments of convergence and divergence in the residents' perspectives (1-3).

Based on the study by Hamui et al. in 2023 (14), The specialties with the highest prevalence of violence were chosen; these were Pediatrics (P), Internal Medicine (IM), Gynecology (G), and Surgery (C). It was also carried out in Ophthalmology (O) because the authorities requested it, although this was not one of the specialties with the highest prevalence of violence. The GFs were carried out with residents of the Single Medical Specialization Plan (PUEM) of the Faculty of Medicine of the National Autonomous University of Mexico. To carry out the GFs, permission was requested from the authorities of the hospital sites to carry them out. Residents in their second year (R2) who had more than one year of experience during the residency and with peers of lower and higher hierarchy were invited to participate voluntarily. The protocol of this study was approved by the Research Ethics Committee of the Faculty of Medicine of the UNAM with number: FM/DI/011/2022.

In order to develop the semi-structured guide for GFs, the researchers involved (a multidisciplinary team made up of two psychologists with postgraduate studies in psychology and medical education, a historian with a postgraduate degree in sociology, and a lawyer with postgraduate studies in gender studies and anthropology) collectively agreed on the questions. The types of violence, the manifestations, the perpetrators, the moments during the residence of greatest violence, the acts of formal denunciation, the consequences, and the actions and practices in response to acts of violence were taken up as a priori categories (15).

The FG sessions were held at the clinical sites where the residents were completing their specialty, in classrooms with privacy conditions so that the interviewees could express themselves openly. The FGs were divided into groups of only men and only women so that they felt more confident to speak. The group of responsible researchers was led by those from outside the hospital institutions, without any academic or work relationship with the residents. The sessions were audio recorded with the informed consent of the participants. During the present study, the researchers involved maintained a constant dialogue about the subjectivities involved in the research process, as well as the contextual aspects that mainly influenced methodological decision-making (16).

As a first level of data analysis, the audios of the focus groups were transcribed, open coding was performed to explore the data, create codes and concepts. Axial coding was then carried out to identify possible connections between the data (17) and finally the data from the different medical specialties were triangulated to find similarities and differences. In a second level of analysis, the concept of microresistances was taken up again (8,11). as a frame of reference to reread the testimonies and reveal the possible dissent of doctors in training in the face of the violence experienced. The approach to resistance since the 1980s has impacted several disciplines to carry out historical and anthropological studies, analysis of companies and daily life (10).

3. Results

Ten focus groups were conducted, two in each of the specialties of pediatrics, gynecology and obstetrics, internal medicine, surgery, and ophthalmology, with 68 participants in total (see Table 1). They were conducted over a period of 9 months, from June 2023 to January 2024, with all

residents from each institution. The duration was approximately one hour and twenty minutes for each GF. The interviewees were open about their experiences and feelings . The point of sufficiency was reached by recognizing the quality of the group interviews, the suitability of the analysis strategy, and therefore the richness of the data obtained (18).

Table 1. Characteristics of the focus groups

Medical specialty	Number of participants
Gynecology	10 women 5 men
Internal medicine	8 women 10 men
Pediatrics	9 women 10 men
Ophthalmology	6 women 2 men
Surgery	6 women 2 men
Total participants	68 residents

The testimonies of residents from different specialties about their experiences of violence were consistent. However, there were narratives with a greater intensity in the emotional charge expressed, accompanied by examples that emphasized more vividly what they experienced. The following table (table 2) shows the main experiences of violence and indicates (with an x) the specialties in which this expressiveness was more marked.

Table 2. Main experiences of violence by medical specialty.

Dimension	**Main manifestations of violence**	**Gynecology**	**Internal medicine**	**Pediatrics**	**Ophthalmology**	**Surgery**
Abuse of power	Humiliation of residents and patients by doctors assigned to them	x	x	x	x	x
	Difficulty in communication channels	x		x		
	Imposition of injustices	x	x	x		
	Devaluation of residents' work			x		x
	Stigmatization	x		x		
	Inclusion and exclusion of service activities and procedures	x	x			x
	Punishment Guards	x	x			
Control	Repetition of punishments towards those of lower rank	x	x			
	Economic retaliation		x			
	Double link communication	x		x		

	Requests during off-hours	x	x			
Disregard for teaching and learning	Few formal learning spaces			x	x	
	Self-taught learning	x	x	x		
	Overflow learning	x	x	x	x	x
	Priority to administrative work			x	x	
	Lack of training in the use of manuals and procedures			x		
	Little effective feedback	x	x	x		
Gag before the complaint	Few effective spaces for reporting	x	x	x		
	Counterproductive responses from authorities	x	x			
	No significant changes are made in response to complaints and claims	x	x	x	x	x
	Response to the scandal			x		

Four general dimensions were extracted from the analysis: 1) abuse of power, 2) control mechanisms, 3) disregard for teaching and learning, and 4) gagging of reporting. These are neither definitive nor exclusive, but are useful for understanding the complexity of the experiences surrounding violence that residents experienced during their training as medical specialists and the micro-resistances they established to mitigate the consequences and not give up on achieving their academic and work goals.

The first dimension, called "abuse of power," was identified in all specialties (see Table 2) and referred to the unfair dominance exercised by higher-ranking physicians over lower-ranking physicians. In these relationships, stigmas, punishments, and exclusion from learning spaces were frequent. Therefore, R2s considered these interactions to be abusive, characterized by unfair impositions, humiliation (mainly verbal), and revenge. R2s also perceived that their work was undervalued despite being essential for medical care, mainly in contexts of healthcare saturation; this situation discouraged the interviewees because they conceived residency as a "bitter step" to achieve a better future. One IM resident and one P resident commented:

Sometimes you think that the six years you spent in medicine were worthless because they treat you as if you knew nothing, it makes you depressed.

You do your best, the best you can, you solve many situations, and they don't see it, they just criticize it, nothing is recognized.

In relation to humiliation, when a doctor (mainly an assigned doctor) was especially aggressive and violent towards someone for any personal characteristic (sex, sexual preference, physical appearance, among others), the students looked for a way to prevent these people (the most abused) from interacting with the aggressor; another person came in their place to prevent the level of violence from becoming too high. The above were acts of protection between colleagues (micro-resistance). An MI resident expressed it:

…I was with only men… they did try to protect me. So I wasn't with that doctor [who was especially aggressive with women], but it was because we all knew what he was like, so [his peers] would tell him: "No, you're not going to be with him" and only men would go with him.

The "control mechanisms" dimension was accentuated in the MI and GO spatialities (see Table 2), and consisted mainly of pressures to perpetuate punishments, economic reprisals, contradictory

messages, unfair requests with consequences for the entire group, and threats of exclusion from learning spaces.

As for the pressures to repeat the punishments, the R2s and R3s (despite not wanting to endorse the violent behavior) had to reprimand the R1s in ways similar to those they experienced when they were R1s; if they did not do so, they were pointed out by the R3s and assigned doctors as people without character or decision, and without the authority that they should show as R2s before others. Two GO residents expressed:

I consider that many of the behaviors that my R3s acquired against us are the ones that we have to present with the R1s, because eventually they [R3s] reprimand us if we do not have them... if we had a punishment when we were R1s, now [that they are R2s] we have to repeat and punish the R1s in the same way... leaving tasks or even allowing them to stay longer [punishment guards]. which involved the deprivation of basic needs such as sleep, rest and adequate nutrition]… whether we like it or not

...they subject you to a chain of abuse, the R4s did the same, if we do not reprimand we are still frowned upon, but it is not only between residents, there is already an agreement between members, pressure is put on the R4 and so on, this type of abuse comes from above, since many were trained in this hospital and so on, until the last link which would be the R1

There were also economic reprisals against R1s and R2s by R3s and attending physicians. For not responding adequately to the resolution of a clinical case or other type of demands during patient care, residents were required to deposit money into a piggy bank called "the pig," as one MI resident explained:

There is a piggy bank called "the pig" for answers to wrong academic questions. You have to pay 5 or 10 pesos to the "pig…if the doctors ask a question and someone doesn't answer correctly you have to pay…I try to hide it so that the truth is, even if the mistake is made, no one pays anything…many are foreigners, they don't have money.

Faced with the obligation to perpetuate the punishments, the micro-resistance on the part of the R2s was to try to subvert them. To do so, they tried not to make the errors of their R1 and R2 colleagues visible in order to avoid both scolding and monetary payment. They mainly protected their colleagues whose economic situation was more disadvantaged.

Contradictory messages (double bind) were also found from senior doctors, which placed the R2s in trapping situations. Any action they took (speaking, keeping quiet, asking, doing or not doing, among others) was wrong and pointed out; the following testimonies from G residents attest to this:

The exact words of the highest-ranking residents: tell us, even if it's wrong we're going to scold you, but tell us, if something is happening and we don't find out we're going to scold you, but if something is happening we're going to scold you, and even if it's not your fault, it's your fault.

The interviewees expressed that during break times they were obliged to respond to requests from senior doctors via WhatsApp (such as questions related to clinical cases) because if they did not do so, there were consequences for the entire R2 group. The following testimony from a GO resident exemplifies this:

…there are times that even if it's a long day, like here at the residence, it ends in the afternoon, once it's finished, everyone goes about their life, it's their time and everyone decides what they do, but with the use of new WhatsApp technologies…there are also ways that the R+ harass because we're in common WhatsApp groups, yesterday it happened that the R+ sent a message and gave one minute to answer, whoever doesn't answer will be punished, sometimes we're coming off guard, we haven't slept and this is the type of harassment that I've experienced, and this causes my colleagues to have to call

me to wake up, almost almost, and you say what happened? -it's that if you didn't answer right now there was going to be a punishment-, so that type of harassment outside of working hours is something that we're suffering and living, sometimes we ignore them but it's always the same punishment.

Inclusion and exclusion from service activities and medical procedures was a weapon that faculty used to manipulate, control, and subjugate residents. Preventing R2s from attending these high-value learning spaces and reducing practice opportunities kept residents feeling vulnerable.

…the bad thing is when they take it against you, like they ignore you, or they take away the procedure, they make you less, but that comes from the assigned ones, who have a disagreement with you, or that you did not act as they wanted, and so they take away procedures from you and to be in a place where you come every day, exposing yourself, getting up early, and even at the cost of your health, to have the procedures taken away from us… there have been cases where the assigned ones are angry with an R3, they ignore them and take away their surgical activities and by not operating they are hitting them where it hurts the most… a hostile way of working is created

The main way of resisting what has been stated in the previous paragraphs was to build alternative spaces of coexistence (outside the clinical premises) to talk about what was happening to them, to vent the feelings experienced, to give each other encouragement and comfort; to criticize the actions imposed and sometimes to appeal to a sense of humor to build a narrative of the events in which the acts of violence were placed in absurd positions. Two P residents expressed:

We hug each other, we cry and we end up laughing at what is happening here, it is absurd, very absurd...

We go out, we see each other outside the hospital to vent, to talk about what is happening to us, how we feel, how we see things, we cry and we laugh, it helps us, it takes away our stress.

Regarding the dimension named "disregard for teaching and learning", this was more noticeable in the specialty of P (see Table 2), referring to the lack of structured educational processes that prevented R2s from conceiving the residency as a space for training and growth as medical specialists. The residents expressed indignation and frustration because the hospital institutions did not show them responsibility and commitment to provide them with formal spaces for teaching and learning. They did not find activities planned and designed to cover the academic programs (which they pointed out as obsolete in some topics): They did not receive training or supervision to avoid making mistakes; feedback was limited to pointing out errors in front of others and they were not evaluated during the procedures they performed. The learning they achieved was self-taught and due to overflow during the excessive demand for medical attention. Two residents from O and one from C expressed:

… I think very little, I mean... we hardly see them [the teachers] for teaching, I mean, their thoughts are: since you are already adults, then take charge of what you have to do, right? If you want to study, study, if you want to research, research…"

"…the important thing is fear, as we are a clinical-surgical specialty, well, it is delicate, because of the lasers, and yes, things can go wrong. They leave us very free, and there is no one to teach you by hand, or someone to teach you how delicate this procedure can be, and accidents can happen, and they have happened…"

"You are under the microscope, if you made a mistake, you are called out in front of everyone…it happens when there are more R+. Mainly in the meeting where everyone is present "in the little room", this leads to the idea that you did it wrong once, they think you do it wrong all the time."

Sometimes administrative work (which was not their responsibility) took away time for patient care, practice or rest. Two comments from C residents speak of this:

> *"It is a hospital that requires too many procedures and everything is very slow. For example, an anesthesiology assistant was refusing us a surgery during the entire night shift, excusing herself that she was busy, that she did not want to see patients. This limits us in our practice and means that the patient does not have the benefit. It does not only depend on us but on other services such as anesthesiology, nursing, and any manager, because there are many things [procedures] to transfer a patient to the operating room, especially with those in anesthesia."*

As a micro-resistance to the lack of formal teaching, during their hours of work in the hospitals, residents looked for spaces (albeit brief) to discuss cases among themselves or ask each other some questions, trying to partially cover the lack of academic spaces. A P resident expressed:

You try to study on your own or you try to do something with your classmates, you get together in your free time to ask each other questions, to learn, it is one's responsibility, but not being given almost anything in the residence, it is not right!

In relation to the dimension "gag in the face of denunciation", it was emphasized in the GO specialty (see Table 2), and involved the difficulties of residents to report and point out situations of violence and harassment that occurred during their training as specialists. Residents avoided making complaints because the channels of communication with the authorities were unreliable, they found these spaces of manifestation ineffective and inconclusive, generally they were given a response to the scandal, but no significant changes were made to avoid violence. In some locations, reporting was counterproductive; expressing and making visible inappropriate behavior led to reprisals against residents or against an entire generation. When expressing dissatisfaction, the institutional response was a warning message not to exercise this right. G residents commented the following:

> *[If residents complain or report] you become the loudmouth, the ungrateful one, the one who can't cope, there is no response, you feel exposed and vulnerable"*
>
> *"They don't pay attention to you, on the contrary [the authorities] take it badly, as if you were the problem."*
>
> *[When a complaint is filed] not only the aggressor is informed, but also all the others who support him, it becomes gossip... and even documents are filed against those who filed the document..."*
>
> *"They don't pay attention to you, on the contrary [the authorities] take it badly, as if you were the problem."*

In most cases, residents chose not to report, remaining silent in the face of what was happening in plain sight. One resident of G commented:

> *…in order to survive the residency we had to refrain from submitting a document [sending a document referring to acts of abuse by an assigned doctor] towards a particular person…*
>
> *When it was made public that we were going to submit the document [referring to the complaint about the behavior of an assigned doctor], we did not do it, the reprisals were worse!*

The limitations of the study are that only one method and one strategy were used to collect data; however, the investigation through focus groups allowed us to find the depth of the phenomenon in the testimonies found.

Discussion

The motives that drive micro-resistance are the moral outrages suffered by the dominated (8). In this sense, the violent acts of the higher-ranking doctors affected the residents, who generated micro-resistances in order not to abandon their goal of becoming specialist doctors. The question

arises as to how the residents configured these micro-resistances in the face of the violence experienced during their training process ? An attempt is made to answer the question with the notion that this is not a finished answer. because interpretations are contextual and open to revision and recontextualization (19). The testimonies revealed that in some discourses, acts and practices - sometimes visible, sometimes hidden from the perpetrators - the residents disguised a certain break with the dominant power discourse, which gave them a relative autonomy that allowed them to continue their medical training.

For De Certeau, micro-resistances must be conceived and revealed in practices rather than in consciences (20). The testimonies highlighted the trick of avoiding contact between the perpetrator and the companions who were more abused. (for any personal characteristic such as sex, sexual preference, physical appearance, among others), were poorly structured acts of protection, which were carried out in the moment and in an improvised manner. The residents established a group dynamic of movement, of play without a pre-established instruction. In this dynamic they did not seek to denounce what was happening in the system, nor to overthrow the perpetrator (8), it was about getting out of the way, stealing the aggressor; without the perpetrator realizing it, the turns were replaced, those less prone to being violated went to meet with the aggressor. In this way they not only looked after the most vulnerable (from the perpetrator's perspective), they also looked after themselves as a group, since the violence observed in a companion also generated a restrictive environment for learning (14).

When having to repeat violent behaviors to prove themselves worthy of being R2, two reactions were found. On the one hand, it was a response to a form of recognition from higher-ranking residents (11) and a form of self-discipline to perpetuate this mode of interaction that characterizes the residences; on the other hand, the residents displayed micro-resistance to this demand; they covered the incorrect responses of their colleagues (mainly R1s), to avoid them having to pay a “pig fee” or having to scold them (in the same way that R2s were reprimanded). This micro-resistance paid them a share of solidarity; it was a way of expressing without words the injustice of being punished for a mistake, when what they should receive for failures was feedback that would allow them to learn.

Micro-resistances often occur in private spaces, where it is assumed that power does not encompass everything, does not colonize the subaltern consciousness (21) . In their scarce free time, residents would frequent places outside the hospitals (restaurants, cafes, bars), where they would turn it into a cathartic space where they would openly express their discontent, tears, and frustration at the moments of violence they had experienced. Empathy and support were demonstrated with words of encouragement and hugs. A sense of humor was common, which enabled them to renew their ideas and practices; it was a way of subverting hegemonic discourses (22). Narrating situations of violence to take them to an extreme of absurdity, dislocated them and transformed indignation into laughter that relieved frustration. According to Nietzsche's positions, laughter could be a powerful act of resistance because it presents a destructive power of the established, to endure what life entails in its constitutive tragedy (23).

In most cases, the consequences of reporting violence to the authorities were counterproductive. Residents therefore chose not to report, using apparent silence as a form of micro-resistance. In this context, micro-resistance was not about enduring violence, but about preventing the emergence of even more intimidating messages and practices that turned the right to report into a double-bind circle (24), from which there was no way out. It was an energetic game with control in constant tension and contradiction.

Sneering, laughing and keeping quiet were the tactics found in the residents' testimonies regarding the grievances they experienced. What is relevant in the face of such micro-resistance is not so much the consequences but the transformative potential that they can have (20) . In this

sense, what do residents manage to transform in these acts of micro-resistance? This may be a pertinent question for future studies. As a way of glimpsing a possible route of inquiry, the following testimony from an IM resident alludes to the possibility of breaking the conception that a certain level of intimidation and humiliation during training is necessary to prepare the physician for a difficult profession (2).

We are a different generation of those who are assigned, we do not seek the same thing, all this is not necessary [referring to acts of violence] to become a specialist, we have other ways, it is not necessary to be bad, to feel bad, to treat others badly…

Residents saw themselves as a distinct generation seeking other ways of doing things and interacting, which can sideline the possibility of change. For Miller, "…neither rebels nor oppressors are monolithic nor are their contours clearly visible (10). Foucault argues that micro-resistances do not have to be large revolutionary movements; they can be gestures, discourses or practices that challenge, question or reconfigure existing power relations; power can be subverted because it is in motion and unstable" (25).

Restrictive environments prevent opportunities for participation and support among fellow residents and limit learning (14). Negative role models (senior residents and attending physicians) can disrupt the ethics and professionalism of physicians in training, mainly affecting empathy with patients (26). Therefore, national and international literature has devoted significant effort to generating and proposing some strategies to restructure hostile learning environments in medical education. Some suggestions are: access to mental health services; adequate, impartial and permanent supervision; emphasis on team-based care at all levels of training; standardisation in access to clinical practice and mentoring; collegial spaces for prompt and impartial attention to violence; and the restructuring of dysfunctional hierarchies (27-28).

5. Conclusions

- Experiences of violence during the training of residents (R2) were revealed, which were manifested mainly in the power abuse relationships between the assigned physicians and the higher-ranking residents, in the lack of structure for educational activities and in the few opportunities to report abuses.
- Complex and contradictory dynamics of control and resistance were established between residents of the different hierarchies.
- The learning environment tended to be restrictive, creating ambivalence in residents about their positions in care services and limiting opportunities for participation and practice.
- Sneak peeks, laugh and remain silent were the micro-resistances that residents encountered in the face of the grievances they experienced. These were located in an energetic game of control in constant tension and contradiction. This allowed residents not to give up on residency and to continue on their path to becoming medical specialists.
- Some strategies to restructure violent environments include access to mental health services, adequate, impartial and permanent supervision, collegial spaces for prompt and impartial attention to violence, and the restructuring of dysfunctional hierarchies.

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