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Learning in the shadows: experiences of the hidden curriculum and gender inequalities in medical training.

Aprender entre sombras: experiencias del currículum oculto y las desigualdades de género en la formación médica.

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Summary.

Background : The medical internship is a central stage in clinical training, where learning transcends technical content and is articulated with relational, emotional, and institutional experiences that influence the construction of professional identity. **Objective:** To understand how trainees interpret their experience during the medical internship and what implicit learning emerges in this formative process. **Method** : A qualitative study with an interpretive phenomenological approach was conducted. In-depth interviews were carried out with medical trainees at a Mexican public university. The analysis was developed through an inductive process of categorization and interpretive reflection. **Results:** The internship is configured as a formative space permeated by hierarchies, institutional demands, and a high emotional load. Through daily practice, trainees incorporate implicit learning related to authority, the management of distress, and legitimate forms of interaction within the hospital environment. These experiences are internalized differently according to gender and contribute both to the reproduction of normalized practices and to processes of critical reflection on medical practice. **Conclusions** : The medical internship serves as a key setting for professional socialization, in which the hidden curriculum plays a central role. Recognizing these dimensions is fundamental to moving towards a more reflective medical education, attentive to human experience and committed to fairer training practices.

Keywords: Medical education **;** Internship; Qualitative research

Resumen.

Antecedentes: El internado médico constituye una etapa central en la formación clínica, en la que el aprendizaje trasciende los contenidos técnicos y se articula con experiencias relacionales, emocionales e institucionales que influyen en la construcción de la identidad profesional. **Objetivo:** Comprender cómo las personas en formación significan su experiencia durante el internado médico y qué aprendizajes implícitos emergen en este proceso formativo. **Método**: Se realizó un estudio cualitativo con enfoque fenomenológico interpretativo. Se llevaron a cabo entrevistas en profundidad con médicas y médicos en formación de una universidad pública mexicana. El análisis se desarrolló mediante un proceso inductivo de categorización y reflexión interpretativa. **Resultados:** El internado se configura como un espacio formativo atravesado por jerarquías, exigencias institucionales y una alta carga emocional. A través de la práctica cotidiana, las personas en formación incorporan

aprendizajes implícitos relacionados con la autoridad, la gestión del malestar y las formas legítimas de relación dentro del entorno hospitalario. Estas experiencias se interiorizan de manera diferenciada según el género y contribuyen tanto a la reproducción de prácticas normalizadas como a procesos de reflexión crítica sobre el ejercicio médico. **Conclusiones**: El internado médico opera como un escenario clave de socialización profesional en el que el currículum oculto desempeña un papel central. Reconocer estas dimensiones resulta fundamental para avanzar hacia una formación médica más reflexiva, atenta a la experiencia humana y comprometida con prácticas formativas más justas.

Palabras clave: Educación médica**;** Internado; Investigación cualitativa

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1. Introduction

In recent decades, medical education has faced the challenge of training professionals capable of responding to increasingly complex social needs. Transformations in health systems have highlighted that the quality of medical care depends not only on technical expertise, but also on the ability to establish human relationships, make ethical decisions, and cope with emotionally demanding contexts (1–2). In this scenario, understanding how future physicians are trained involves considering not only the explicit content of curricula, but also the learning that occurs in the daily experience of clinical settings (3–4).

Several studies have indicated that a substantial part of medical learning occurs through practices, norms, and values that are not always formalized in the curriculum. These experiences, gained through daily interactions within hospitals and health services, influence how students interpret professionalism, the treatment of patients and colleagues, and legitimate ways of responding to fatigue, authority, and institutional pressure (3–7). The coexistence of a formal curriculum oriented toward ethical and humanistic principles with implicit practices that prioritize efficiency, hierarchy, or resilience to burnout generates tensions that permeate medical training from its earliest stages (2–3, 8–10). From this perspective, gender is central to understanding how these experiences are lived and given meaning. In this study, gender is conceived as a relational and contextual framework that organizes expectations, practices, and power relations in medical training settings, rather than as an individual characteristic. Implicit gender norms influence the distribution of tasks, forms of academic recognition, and the ways in which certain behaviors or emotional expressions are legitimized within the hospital environment (11-13). This approach allows us to analyze how training experiences acquire different meanings without assuming essential differences between men and women (12, 14-15).

The adoption of this gender perspective is articulated with an interpretive phenomenological approach, centered on lived experience and the meanings that individuals attribute to their training process. From this perspective, the study's interest is not directed at explaining experiences based on predefined categories, but rather at understanding how hierarchical relationships, institutional dynamics, and gender norms permeate the medical internship as experienced by those who undergo it (16–17). Gender thus operates as an interpretive lens that guides the reading of the narratives, allowing for the identification of tensions, nuances, and regularities in the recounted experiences.

The medical internship represents a key moment in professional training, as it marks the transition between academia and clinical practice. During this stage, students assume real responsibilities in contexts characterized by a high workload, marked hierarchical structures, and limited opportunities for systematic reflection (3,8-10). These conditions make the internship a privileged setting for exploring how implicit learning is constructed and how it influences the way students experience the medical profession.

This study aims to analyze the manifestations of the hidden curriculum during medical internships and how these experiences influence the construction of meanings about professional practice, paying attention to the gender dynamics that permeate clinical training. Using an interpretive qualitative approach, it seeks to account for the experiences of newly graduated physicians, focusing on their daily experiences and the meanings they attribute to their training process.

2. Methods

A qualitative study with an interpretive phenomenological approach was conducted to understand how trainees make sense of their experience during medical internships and how implicit learning associated with this training process is configured. This approach is relevant for exploring complex and lived phenomena, such as the hidden curriculum, which is expressed through unwritten norms, power relations, and everyday practices in clinical settings. From an interpretive phenomenological perspective, it is assumed that experience cannot be separated from the meanings that people attribute to it and that analysis necessarily involves situated interpretive work (18). In the field of medical education, this approach has been used to analyze invisible training processes, institutional hierarchies, and tensions that permeate the construction of professional identity (19).

2.1 Participants and context

Participants were selected using purposive sampling, prioritizing cases that provided relevant information related to the study's objective. Twenty medical students in training during their internship, graduates of the Medical Surgeon program at the National Autonomous University of Mexico, Faculty of Higher Studies Iztacala, who completed their internship between July 2021 and June 2022, were interviewed. The clinical sites included public institutions (IMSS, ISSSTE, and hospitals of the Ministry of Health), as well as private hospitals, allowing for the exploration of training experiences in diverse organizational contexts. The number of interviews was determined based on the principle of information sufficiency inherent in qualitative research, prioritizing the depth and richness of the narratives over sample size.

2.2 Information gathering techniques

The information was gathered through semi-structured individual interviews, lasting approximately 40 to 60 minutes. This format allowed for a common thematic guide while also encouraging the free expression of experiences during the medical internship. Topics covered included the organization of clinical work, hierarchical relationships, teaching and learning dynamics, and the emotional experiences associated with the training process. Prior to each interview, the purpose of the study was explained, the confidentiality of the information was guaranteed, and written informed consent was obtained. During fieldwork, field notes and analytical memos were prepared to accompany the analysis process.

2.3 Analysis Strategy

The data analysis was conducted using a reflective thematic analysis with a phenomenological approach. Initially, the interviews were read repeatedly to foster a deeper understanding of the narratives and the meanings attributed to the medical internship. This phase allowed for a sensitive approach to the content of the narratives before any analytical organization. Based on these readings, an open coding process was carried out, focused on identifying relevant units of meaning related to the educational experience, institutional dynamics, and relationships within the clinical context. The coding was performed by the principal investigator, who has training and experience in qualitative research in medical education. The initial codes were iteratively reviewed and reorganized, resulting in broader analytical groupings that facilitated a more integrated interpretation of the data.

The analysis was conducted manually, prioritizing an interpretive and reflective reading of the narratives over mechanical coding procedures. Throughout the process, regular analytical discussions were held with colleagues from the research team, aimed at comparing interpretations, reviewing analytical decisions, and strengthening the reflexivity of the analysis. These discussions allowed for refining the construction of categories and reducing potential interpretive biases. By way of illustration, some of the initial codes identified included: task overload, differential treatment, observational learning, normalization of fatigue, and negotiation of one's place in the hierarchy. These codes served as a starting point for exploring patterns, tensions, and nuances in the experiences narrated by the participants, always remaining grounded in their accounts and the institutional context in which the study was conducted.

2.4 Methodological rigor

To strengthen the study's credibility, strategies such as analytical reflexivity, peer review, and feedback of preliminary findings to some participants (member checking) were implemented. Although the study relied on a single source of information, these strategies helped maintain the coherence and consistency of the analysis.

2.5 Ethical considerations

The study was conducted in accordance with the ethical principles set forth in the Declaration of Helsinki and with international recommendations for qualitative research in the health sciences. Participation was voluntary, and all participants received clear and sufficient information about the study's objectives, data collection procedures, and the academic use of the data. Before conducting the interviews, written informed consent was obtained, guaranteeing anonymity, data confidentiality, and the right to withdraw from the study at any time without academic or professional consequences. Names and identifiable information were replaced with alphanumeric codes to protect the identity of the interviewees. The study was reviewed and approved by the Ethics Committee of the Faculty of Higher Studies Iztacala of the National Autonomous University of Mexico (file number CE/FESI/112025/2065), with an approval date of November 15, 2025.

3. Results

The data were analyzed using a qualitative, categorical, interpretive analysis with a phenomenological approach and a gender perspective. The categories were inductively constructed from the narratives and organized into subcategories that allowed for an account of the lived experience during the medical internship. The results, organized by analytical categories, are presented below (Table 1). Each of these areas incorporates interview excerpts that illustrate how participants interpret their experiences in different clinical contexts. To contextualize the quotes, the participant's gender and the type of institution where they completed their internship are indicated, differentiating between public (HP) and private (HPv) institutions. This analysis did not aim to quantify the themes, but rather to understand the essence of the experiences and the meanings associated with them, emphasizing the emotions, dilemmas, and lessons learned throughout this formative period.

Table 1. Categories and subcategories of the qualitative study.

Categories	Subcategories
Roles and learning during medical internship	Performing tasks that exceed the educational role
	Learning built through everyday practice
	Intensification of the role during on-call shifts
	Bodily and emotional experience of learning
	Valued training experiences and teacher support
Hierarchies, treatment and power relations during medical internship	Hierarchical treatment and devaluation of the inmate's role
	Normalizing abuse as part of education
	Silence and fear of the consequences
	Hierarchical relationships permeated by gender
	Strategies of adaptation and relational resistance
Gender, body and regulation of behavior during medical internship	Surveillance of body and appearance
	Sexualization and gendered comments
	Differentiated regulation of behavior
	Subtle harassment and relational ambiguity
Personal, emotional, and professional repercussions of medical internship	Emotional exhaustion and sustained burnout
	Normalization of distress and delegitimization of emotional care
	Impact on personal life and significant relationships
	Gender differences in the experience of discomfort
	Impact on professional identity in training
Institutional conditions and teaching support during the medical internship	Insufficient institutional monitoring
	Fragmentary teaching and institutional support
	Material conditions for rest and self-care

3.1 Category A. Roles and learning during medical internship.

From a phenomenological perspective, the narratives allow us to understand the medical internship as a complex formative experience in which learning is constructed through sustained participation in hospital work. Training is not limited to the progressive acquisition of clinical skills, but also involves the integration of the professional role under conditions of high institutional demands, continuous workload, and limited faculty support. In this context, learning and working are constantly intertwined, blurring the boundaries between training and clinical practice. This category is organized into five interrelated subcategories: (1) performing tasks that exceed the training role; (2) learning constructed through daily practice; (3) intensification of the role during on-call shifts; (4) the embodied and emotional experience of learning; and (5) valued training experiences and faculty support.

3.1.1 Performing tasks that exceed the formative role

A central part of learning during internships occurs through the performance of clinical and administrative tasks that extend beyond the formal framework of the intern's role. These activities are integrated into the daily dynamics of the services as standardized and indispensable practices for their operation. However, their meaning varies according to the subjective perspective from which they are experienced. In women's accounts, these tasks are associated with experiences of exposure, uncertainty, and responsibility assumed under conditions of limited supervision, particularly when they involve clinical decision-making.

"I think 90 percent of what I did was not my responsibility. In surgery, I ended up doing rounds alone, receiving admissions, taking notes, and modifying treatments because the doctors weren't there" (Woman, HP).

In contrast, in men's accounts, these same practices tend to be interpreted as part of professional learning and as opportunities to appropriate the language and logic of clinical work:

"Although it may sound a bit pathetic, just by writing a note you learn medical language, and right now that we are in training that is super useful" (Man, HP).

These differences demonstrate that the hidden curriculum conveys differentiated implicit expectations regarding responsibility and legitimacy in exercising the professional role.

3.1.2 Learning built in everyday doing.

Learning during the internship is fundamentally situated learning, anchored in direct experience and continuous contact with patients. Learning is associated more with participation in service tasks than with explicit instruction.

"You learned everything as you went along, by watching and doing, although you didn't always know if you were doing it right" (Man, HP).

In women's experiences, this practical learning is marked by a greater awareness of the sustained effort and emotional demands involved in responding simultaneously to multiple demands:

"You learned a lot, but you also felt like you never stopped, that there was always something more to do" (Woman, HP).

3.1.3 Intensification of the role during on-call shifts

On-call shifts emerge as moments of intensified training. During these shifts, the expansion of responsibilities and the concentration of tasks in contexts of extreme fatigue create experiences marked by sustained demands.

"That was when you learned the most, but also when the most was demanded of you" (Man, HP).

In women's accounts, these experiences are associated with a greater sense of vulnerability and the need to respond without room for error:

"At night you were practically alone, and anything that happened was your responsibility" (Woman, HP).

3.1.4 Bodily and emotional experience of learning

Learning during the boarding school is experienced as a deeply embodied process. The body appears as the site where the formative demands are inscribed, through fatigue, sleep deprivation, and emotional exhaustion.

"There were days when your body couldn't take it anymore, but you had to keep going" (Woman, HP).

In other accounts, exhaustion is integrated as an expected and normalized condition of the training process:

"You knew you were going to be tired, it was part of boarding school" (Man, HP).

3.1.5 Valued training experiences and teacher support

In contrast to a dynamic predominantly focused on workload, the most valued training experiences are those in which there is genuine teacher support, based on supervision and feedback:

"When someone explained something to you, you felt like you weren't just working, but really learning" (Woman, HP).

These experiences introduce tensions between a pedagogy focused on the operational resolution of service demands and training practices that recognize the need for support, reflection, and supervision. In this sense, the hidden curriculum defines which forms of teaching are considered legitimate and which are marginal within the hospital setting.

3.2. Category B. Hierarchies, treatment and power relations during medical internship.

Medical internships take place in a highly hierarchical hospital environment, where power dynamics constantly permeate the daily experiences of trainees. Through repeated interactions with residents, attending physicians, and other authority figures, implicit learning is formed regarding one's place within the institutional structure, expected behaviors, and possible scopes of action. These dynamics not only organize clinical work but also shape the training experience and the ways in which trainees feel a sense of belonging to the healthcare team. This category is organized into five interrelated subcategories: (1) hierarchical treatment and devaluation of the intern's role; (2) normalization of mistreatment as part of training; (3) silence and fear of the consequences; (4) hierarchical relationships shaped by gender; and (5) strategies of adaptation and relational resistance.

3.2.1 Hierarchical treatment and devaluation of the inmate's role.

Hierarchical treatment appears as a structural feature of the internship and manifests itself through public corrections, reprimands, belittling, or forms of invisibility that reinforce the students' subordinate position. These practices are integrated into the daily dynamics of the hospital and, in lived experience, define the intern's place within the healthcare team. In women's accounts, this treatment is experienced with a strong emotional charge and a persistent feeling of exposure in front of patients and other professionals.

"Sometimes they would talk to you as if you didn't know anything, even in front of the patients. They would correct you harshly and you felt like you couldn't say anything" (Woman, HP).

In men's accounts, these practices tend to be integrated as an inherent part of hospital operations:

"You knew you were downstairs and that's how the hospital worked" (Man, HP).

3.2.2 Normalization of mistreatment as part of training

Everyday mistreatment is legitimized through discourses that present it as a necessary component of medical training. Expressions like "that's just how internships are" operate as mechanisms that deactivate criticism and reinforce the acceptance of authoritarian practices.

"They always told you not to take it personally, that's how you learn in the hospital" (Man, HP).

In contrast, some women identify these practices as sources of distress, even when they are considered normalized:

"They said it was normal, but it did affect me" (Woman, HP).

3.2.3 Silencing and fear of the consequences

Questioning authority or expressing disagreement is perceived as risky due to the possibility of academic or relational retaliation. Silence emerges as a frequent self-protective strategy.

"You preferred not to say anything because you knew that it could harm you later" (Woman, HP).

In other accounts, silence is linked to a pragmatic logic of institutional survival:

"It wasn't worth getting into trouble" (Man, HP).

3.2.4 Hierarchical relationships permeated by gender

Hierarchical relationships are not experienced neutrally. In women's experiences, there is greater surveillance of behavior, speech patterns, and how they occupy hospital space.

"Women were told more about how we had to behave" (Woman, HP).

In men's accounts, the demands are mainly focused on the fulfillment of clinical tasks:

"As long as you did what you were supposed to do, there wasn't so much of a problem" (Man, HP).

3.2.5 Adaptation strategies and relational resistance.

Faced with these hierarchical dynamics, trainees develop strategies to sustain their time in the boarding school, ranging from emotional distancing to peer support:

"We supported each other, that helped us cope with the treatment" (Woman, HP).

These strategies show that, even in highly hierarchical contexts, people in training deploy margins of agency to protect themselves and continue their training process.

3.3 Category C. Gender, body and regulation of behavior during medical internship.

The medical internship is configured as a formative space in which the body and behavior acquire particular centrality, not only as supports for clinical learning, but also as objects of implicit regulation. Beyond formal content, daily experience transmits tacit norms about how to present oneself, behave, and occupy professional space. These regulations, shaped by gender, are learned progressively and condition the legitimate forms of presence within the hospital environment.

3.3.1 Surveillance of body and appearance

The regulation of the body emerges as a daily experience during hospitalization, especially in relation to clothing, personal presentation, and how one occupies the clinical space. These observations function as mechanisms of symbolic control that define which bodies are acceptable and under what conditions they can move about the hospital environment. In women's accounts, this surveillance is experienced as constant observation that generates discomfort, self-control, and a continuous adjustment of one's own behavior.

"Sometimes they would tell you how you had to dress or groom yourself, even if you were wearing the uniform. You felt like you were always being watched" (Woman, HP).

"Even though you were just like everyone else, you felt that they did see you" (Woman, HP).

In contrast, in men's accounts, body image does not emerge as a problematic issue, provided that assigned tasks and clinical performance expectations are met:

"They never said anything to me about how I was dressed; as long as I did my job, there was no problem" (Man, HP).

"I was never called out for that" (Man, HP).

These differences show that body surveillance does not operate homogeneously, but is exercised in a differentiated way according to gender, constituting an implicit learning about the limits and legitimate forms of professional presence during the medical internship.

3.3.2 Sexualization and gender-laden comments

Another relevant dimension of bodily and behavioral regulation during boarding school is expressed in the presence of gendered comments, jokes, or insinuations that generate discomfort and reinforce relational asymmetry. These experiences are often presented ambiguously and as naturalized, making them difficult to identify and confront, especially when they come from figures with higher institutional authority. In women's accounts, these comments are experienced as persistent sources of tension and surveillance over their own bodies and behavior.

"There were comments that made you feel uncomfortable, but you didn't know how to say anything because they came from someone above you" (Woman, HP).

"It wasn't direct, but it did make you feel out of place" (Woman, HP).

In contrast, in men's accounts, this type of interaction tends to be minimized or not recognized as problematic, becoming integrated into the daily dynamics of the hospital without generating explicit questions:

"I heard jokes, but I didn't really pay attention to them" (Man, HP).

"I didn't see it as something serious" (Man, HP).

These differences demonstrate that sexualization operates unequally in the educational experience, affecting in a differentiated way the perception of safety, belonging and legitimacy within the hospital space.

3.3.3 Differentiated regulation of behavior

Medical internships also convey implicit expectations about how to behave, speak, and react in different clinical and relational situations. These expectations are not applied uniformly and are articulated with gender norms that regulate emotional expression, assertiveness, and hierarchical positions. In women's accounts, a greater demand for restraint, kindness, and self-control emerges, as well as a fear of being negatively interpreted for behaviors that deviate from these norms.

"If you got angry or answered back, they immediately said you were troublesome. You had to be very careful" (Woman, HP).

"You felt like you couldn't show yourself as you were, because anything could be misinterpreted" (Woman, HP).

In men's stories, similar behaviors tend to be interpreted differently and read as signs of character, leadership, or firmness, without generating comparable sanctions:

"If you raised your voice, it was more like you were imposing yourself" (Man, HP).

"Nobody thought it was strange" (Man, HP).

These differences show how the regulation of behavior functions as implicit learning that reinforces gender roles within the hospital space and conditions legitimate forms of expression and participation during internship.

3.3.4 Subtle harassment and relational ambiguity

Some of the experiences described are not explicitly labeled as harassment, but they generate discomfort due to their ambiguous nature and the difficulty in establishing clear boundaries within a hierarchical context. This ambiguity increases vulnerability, especially when the interactions come from figures with formal or informal authority, and fosters processes of doubt and self-questioning. In women's accounts, these situations are experienced as persistent discomfort that is difficult to verbalize or report.

"It wasn't something direct, but it did make you feel uncomfortable, like you didn't know if you were exaggerating or not" (Woman, HP).

"You kept wondering if you were wrong for feeling that way" (Woman, HP).

In men's accounts, these situations tend to go unnoticed or not be identified as problematic within the daily dynamics of the hospital:

"Sometimes you don't even realize those things" (Man, HP).

"I didn't notice it" (Man, HP).

This difference in perception shows how subtle bullying is easily made invisible and normalized as part of the educational environment, reinforcing implicit learning about which experiences are legitimate to name and which should remain in the realm of the unspoken.

3.4 Category D. Personal, emotional and professional repercussions of the medical internship.

The medical internship produces effects that transcend the strictly academic sphere and permeate the emotional, relational, and professional lives of those who undertake it. The conditions of sustained pressure, the normalization of discomfort, and the limited legitimacy of caregiving shape a formative process whose impacts accumulate and are progressively developed throughout the

internship. This category allows us to understand how the hidden curriculum molds subjectivities, coping mechanisms, and ways of relating to the medical profession.

3.4.1 Emotional exhaustion and sustained burnout

The strain associated with internships is not limited to the physical fatigue resulting from long days, but manifests as persistent emotional exhaustion that permeates various aspects of daily life. Trainees describe a feeling of constant overload and difficulty in regaining energy even outside the hospital setting.

"There came a point where it wasn't just physical exhaustion anymore, it was like being emotionally drained all the time" (Woman, HP).

"Even when you slept, you felt like you weren't resting, like you were always in alert mode" (Man, HP).

3.4.2 Normalization of discomfort and delegitimization of emotional care.

The emotional distress that accompanies hospitalization is reinterpreted within a cultural framework that presents it as inevitable and necessary. Discourses circulate in the hospital environment that discourage acknowledging suffering, associating the expression of it with weakness or a lack of vocation.

"They told you it was normal to feel that way, that it happened to everyone and that you shouldn't complain" (Man, HP).

"Although I felt bad, I thought I had no right to say anything because I was part of the boarding school" (Woman, HP).

These discourses shift emotional care to the individual sphere and make invisible the structural conditions that generate discomfort.

3.4.3 Impact on personal life and significant relationships

The demands of boarding school generate a profound reorganization of daily life, affecting the temporal and emotional availability to maintain meaningful relationships. Over-involvement in the educational role takes precedence over other areas of life, producing distancing and relational strain.

"I hardly ever saw my family, and when I was with them I was in a bad mood or very tired" (Woman, HP).

"My personal relationships cooled down because I was always in the hospital" (Man, HP).

3.4.4 Gender differences in the experience of discomfort

The experience of distress during boarding school takes on different nuances depending on gender. In women's accounts, suffering is often accompanied by processes of self-questioning and self-criticism, in which the distress is interpreted as a personal failing rather than as an effect of the educational context.

"I felt that if I couldn't handle everything, it was because I wasn't strong enough" (Woman, HP).

In contrast, in men's narratives, discomfort tends to be managed through minimization or silencing, becoming integrated as an expected condition of the formative process:

"You get used to it and keep going, it's not something you think about much" (Man, HP).

3.4.5 Repercussions on professional identity in training

The experiences gained during the internship significantly influence the construction of professional identity. The training process may be accompanied by doubts, disillusionment, or questioning about the choice of career, or by an emotional hardening that functions as an adaptation strategy in the face of a highly demanding environment.

"There were times when I wondered if I really wanted to continue in medicine" (Woman, HP).

"You learn to toughen up, because otherwise you can't take it" (Man, HP).

Taken together, these repercussions show that the internship not only transmits clinical skills, but also emotional and ethical dispositions that will accompany future professional practice.

3.5 Category E. Institutional conditions and teaching support during the medical internship.

The institutional conditions surrounding medical internships create a formative framework that, while often overlooked, is crucial to the daily learning experience. More than a neutral backdrop, the internship's institutional organization (in terms of academic monitoring, faculty support, and material resources) conveys implicit lessons about the role of care, mentorship, and responsibility within medical training.

3.5.1 Insufficient institutional monitoring

The accounts show that, once they join the hospital, trainees perceive a gradual disconnection from the training institution. The absence of systematic academic and training monitoring mechanisms generates a feeling of helplessness and a lack of clear role models to face the daily difficulties of internships.

"The teaching staff never verified that they actually took charge… I wish they had meetings to see how the interns were performing, but they never did anything like that" (Man, HP).

"They abandon you, there is no support… if you are already in the hospital, you already belong to the hospital" (Woman, HP).

This lack of follow-up operates as an implicit message that normalizes forced self-sufficiency and discourages the search for institutional support.

3.5.2 Fragmentary teaching and institutional support

When institutional or teaching support does appear, it is sporadic and dependent on specific individuals, rather than as part of a structured support system. This fragmentation introduces a logic of randomness into the learning experience, where access to support is not guaranteed, but rather conditioned by particular circumstances.

"When I needed to talk to someone from the faculty, they attended to me, but it wasn't a constant thing" (Woman, HP).

"The greatest support I received was that they referred me to psychology, and I am grateful for that" (Man, HP).

The sporadic nature of this support reinforces the idea that care is an exception and not a sustained institutional responsibility.

3.5.3 Material conditions for rest and self-care

The material conditions intended for rest and self-care occupy a marginal place within the organization of the boarding school. The accounts reveal a high degree of variability between locations and services, as well as a systematic subordination of rest to care demands.

"The room was super dirty, almost nobody slept there… you only went because you couldn't stand it anymore" (Woman, HP).

"In some services they did let us rest and that made a difference" (Man, HP).

These experiences reveal an institutional logic that conceives of the inmate's body as an available resource, transmitting the implicit learning that self-care is not a formative priority.

Category E reveals that institutional conditions and faculty support implicitly define the scope of protection, support, and well-being during medical internships. Insufficient monitoring, fragmented support, and precarious material conditions not only affect daily experiences but also shape implicit learning that normalizes burnout and places individual responsibility for care, reinforcing a hidden curriculum focused on resistance rather than institutional support.

4. Discussion

The results of this study allow us to understand the medical internship as a central process of professional socialization in which learning is fundamentally constructed through daily immersion in hospital work. Beyond the acquisition of clinical skills, the internship involves the incorporation of

implicit norms related to authority, fatigue management, emotional regulation, and legitimate forms of interaction within hierarchical institutional structures. These findings are consistent with classic and contemporary literature on the hidden curriculum in medical education, which has shown how a substantial part of professional learning occurs outside of formal programs, through practices, routines, and power relations that shape medical identity (20-21).

In line with previous studies, the results show that hospital hierarchies function as formative devices that organize not only clinical work but also the subjective positions of those in training. Through repeated interactions with residents and attending physicians, interns learn to anticipate consequences, regulate their behavior, and manage silence as a strategy for institutional survival. This type of implicit learning has been described as a central mechanism of cultural reproduction in medicine, through which authoritarian practices are normalized and specific conceptions of professionalism are transmitted (22).

Incorporating a gender perspective allows for a deeper understanding of these dynamics by showing that training experiences are not homogeneous. In this study, women's accounts reveal greater exposure to body surveillance, behavioral regulation, and self-questioning in the face of discomfort, while men's accounts tend to interpret the demands of internships as necessary tests of professional strength. These findings align with research that has documented how gender norms operate implicitly in medical training, producing differentiated trajectories and reproducing symbolic inequalities within the clinical setting (11-14) .

The emotional impact of internships emerges as a cross-cutting theme in the results. Sustained burnout, the normalization of suffering, and the delegitimization of emotional care are integrated as implicit learning experiences that reinforce a conception of professionalism based on resilience and self-control. Several studies have warned that the training culture in medicine tends to make the subjective costs of clinical learning invisible, favoring the acceptance of discomfort as an inherent part of training and shifting the responsibility for care to the individual sphere (23-24).

However, the results also reveal the ambivalent nature of medical internships. Alongside dynamics that perpetuate mistreatment and burnout, experiences of teacher support and peer support emerge, introducing fissures in the dominant hidden curriculum. These experiences have been identified in other studies as protective factors that allow for a reinterpretation of the training experience and the development of a more reflective and ethical professional identity, even in highly demanding contexts (25-26).

From an institutional perspective, the findings underscore the importance of organizational conditions and academic monitoring during internships. The fragmentation of teaching support, the absence of systematic mentoring mechanisms, and the precariousness of material conditions for rest create a training framework that reinforces forced self-sufficiency and the normalization of burnout. This situation has been documented in various medical training contexts and is associated with higher risks of burnout, cynicism, and early professional disengagement (23-24).

Taken together, this study provides qualitative evidence that reinforces the need to analyze medical internships as a complex training process, shaped by power relations, gender norms, and institutional conditions that decisively influence the construction of professional identity. Integrating these dimensions into the analysis and design of clinical training is a necessary step toward a more reflective, equitable, and human-centered medical education that is attentive to the experiences of trainees.

Limitations of the study

This study has some limitations that should be considered when interpreting the findings. First, it is a qualitative study conducted within a specific institutional context (a medical program at a Mexican public university) and during a specific period, which limits the scope of the results. From an interpretive qualitative perspective, the findings do not aim for statistical generalization, but rather to provide situated insights that may be transferable to similar educational contexts, provided that the institutional and cultural particularities of each environment are taken into account.

Furthermore, the purposive and voluntary sampling may have favored the participation of individuals more inclined to reflect on their educational experience, introducing a potential selection bias. The relationship between the researchers and the participants, framed within a shared academic context, may also have influenced how the experiences were narrated. While this closeness fostered trust and depth in the accounts, it is important to acknowledge its potential influence on the interpretive process. Finally, the study relied on a single data source (interviews), without methodological or source triangulation, which limits the possibility of comparing the findings with other empirical data. Nevertheless, the internal consistency of the analysis and the richness of the narratives support the interpretive validity of the presented results.

5. Conclusions

- The medical internship is a key moment in professional socialization where, in addition to clinical skills, interns learn implicit norms related to hierarchy, managing distress, regulating behavior, and legitimate forms of participation in the hospital environment. These lessons, part of the hidden curriculum, directly influence the development of professional identity.
- The results show that these dynamics develop in institutional contexts that normalize burnout and shift caregiving responsibilities to the individual sphere. From a gender perspective, these conditions generate differentiated formative experiences, particularly regarding body policing, behavioral regulation, and identity adjustment processes.
- While the internship replicates practices that can negatively impact the well-being of trainees, it also includes experiences of faculty mentorship and peer support that allow for a reinterpretation of the training process. Recognizing these tensions is fundamental to understanding the medical internship as a complex educational space and to moving towards more reflective models of medical education that are sensitive to the human experience of those in training.

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