Gender-based violence and abuse in medical training in Mexico before, during, and after the COVID-19 pandemic: Signs of hysteresis in the medical field?

Violência e abuso de gênero na formação médica no México antes, durante e depois da pandemia de COVID-19: sinais de histerese na área médica?

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Abstract

In this article, we describe the protests that shook the medical field in the years leading up to the COVID-19 epidemic in Mexico. On the one hand, there were protests by the medical profession against different forms of violence related to organized crime in the context of the so-called war on drugs. On the other hand, there were protests by the feminist movement against gender-based violence within the medical field. We point out the need to more systematically investigate the differential course of these struggles, with only the feminist movement appearing to advance toward producing a possible state of hysteresis of the patriarchal habitus within the field. The article begins with a brief conceptual and methodological note. Next, we show the momentum that the two types of protests against violence in the medical field were gaining. We then seek to illustrate how the basic structures of the field, related to medical training (precariat and authoritarianism), operated to the detriment of these protests, but apparently with different effects. We conclude the article with a reflection on the course these struggles have taken since then, asking whether it is possible to speak of a current state of partial hysteresis within the medical field.

Keywords: Medical Field; Mexico; Feminist Struggles; Violence; Hysteresis.

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Resumo

Este artigo descreve os protestos que abalaram o campo médico nos anos que antecederam a epidemia de COVID-19 no México. Por um lado, houve protestos da classe médica contra diferentes formas de violência relacionadas ao crime organizado no contexto da chamada guerra às drogas. Por outro lado, houve protestos do movimento feminista contra a violência de gênero no campo médico. Apontamos a necessidade de investigar mais sistematicamente o curso diferencial dessas lutas, com apenas o movimento feminista parecendo avançar em direção à produção de um possível estado de histerese do habitus patriarcal no campo. O artigo começa com uma breve nota conceitual e metodológica. Depois mostramos o impulso que os dois tipos de protestos contra a violência no campo médico estavam ganhando. Em seguida, buscamos ilustrar como as estruturas básicas do campo, relacionadas à formação médica (precariado e autoritarismo), operaram em detrimento desses protestos, mas aparentemente com efeitos distintos. Concluímos o artigo com uma reflexão sobre o curso que essas lutas tomaram desde então, questionando se é possível falar de um estado atual de histerese parcial no campo médico.

Palavras-chave: Campo Médico; México; Lutas Feministas; Violência; Histerese.

Introduction

This article is grounded on the idea that it is impossible to study abuse in medical training during the COVID-19 pandemic without addressing the history of the medical field – that is, the struggles, readjustments, and changes within it, as well as in the more immediate historical context of the health emergency. In Mexico, the COVID-19 pandemic did not disrupt the functioning of a stable medical field, but instead found itself in a turbulent field. In the years leading up to the pandemic, two protest movements had been developing within this social space. On the one hand, beginning in the second decade of the 21st century, the medical profession began to protest against several forms of violence affecting healthcare professionals. These were mostly related to the increasing violence generated by organized crime in the context of the so-called war on drugs (Castro; Villanueva, 2018). On the other hand, the feminist movement, which gained much strength in our country due to the increase in femicides, also included medical students who, in the context of #MeToo, began to protest against gender violence within the medical field (Villanueva, 2025). The evolution of both movements seemed to be shaking up some of the structures of the Mexican medical field until the COVID-19 pandemic emerged, when the protests appeared to be neutralized by the effects of the dynamics imposed by the health emergency.

Five years into the pandemic, in this article, we first aim to describe the protests that shook the medical field in the years leading up to the health emergency. Then, we suggest the need to more systematically investigate the differential course of these struggles, with only one, that of the feminist movement, appearing to advance toward the production of a possible state of hysteresis of the patriarchal habitus within this field.

The article begins with a brief conceptual and methodological note in which we revisit Bourdieu's concept of "hysteresis" and describe the origin of the testimonies that serve as empirical evidence. We then show the momentum that the two types of protests against violence in the medical field we

have highlighted were gaining: violence in general, and gender-based violence. We then seek to illustrate how the basic structures of the field, related to medical training (precariat and authoritarianism), operated to the detriment of these protests, but apparently with different effects. We conclude the article with a reflection on the course these struggles have followed since then, asking whether it is possible to speak of a current state of partial hysteresis within the medical field.

1. A conceptual and methodological note

Bourdieu defines the concept of "hysteresis" as the mismatch between the habitus of an individual or group and the objective conditions of the field in which they operate: "it happens, in particular, when a field experiences a profound crisis and its regularities (even its rules) are profoundly disrupted" (Bourdieu, 1999, p. 210). Perhaps this has been the case in the medical field in the context of feminist struggles against gender-based violence within it and, particularly, in the context of the COVID-19 pandemic. In the latter case, moreover, precariousness, along with unequal risk distribution, became a central feature of the health emergency (Graham, 2020).

The analysis presented here is based on the work that both authors have been conducting in recent years in the medical field. On the one hand, one of the authors of this work conducted four focus groups between 2021 and 2022 with female Mexican medical students and medical professionals (Table 1). The topics discussed in these focus groups included, among others, gender-based violence during medical training and professional practice, as well as feminist protests within the medical field in the months leading up to the COVID-19 pandemic. Furthermore, between 2021 and 2022, the other author of this work conducted 19 in-depth interviews with medical residents who were seeking legal advice for the extreme abuse they were experiencing as residents. For this work, we focused the analysis of these interviews primarily on the months of the COVID-19 pandemic.

2. Abuse in medical training: an event with a history within the medical field

Medical abuse during medical training has been documented since the middle of the last century (Cook et al., 1996; Li et al., 2010). The 2014 issue of Virtual Mentor, the academic journal of the American Medical Association, dedicated to this issue, is particularly noteworthy. That same year, a meta-analysis of 51 international studies published between 1987 and 2011 revealed that this was a widespread situation, not limited to certain countries or academic programs (Fnais et al., 2014). That publication estimated that 59.4% of medical students and 63.4% of residents experienced some form of abuse during their training. Gender-based violence was the most common form of abuse, with 49.8% of students and 66.6% of residents experiencing gender discrimination, and 33.3% and 36.2% experiencing sexual harassment, respectively. Other publications indicated that the most vulnerable medical students were women and other members of minority groups (Ogden et al., 2005), especially in traditionally male-dominated specialties such as surgery (Cassell, 1997; Witte; Stratton; Nora, 2006).

In Mexico, one of the authors of this article explored the different forms of abuse and discipline suffered by medical students and which are the basis of authoritarian medical practices and obstetric violence (Castro, 2014). This research identified a gender-based disciplining system operating within the hidden curriculum of medical education in Mexico, which systematically constructs women as sexualized objects rather than students, thereby assigning them a subordinate position in Medicine. For her part, the other author of this work documented the differential treatment by gender that medical students systematically receive, based on a normalized and open male competition to "conquer" them, which ends up translating into experiences of sexual harassment of the students by professors and higher-ranking doctors (Villanueva, 2019).

Table 1 - Focus groups.

Group	Population	Participants
1	Female students aged 20-24	6
2	Female doctors aged 25-31	4
3	Female doctors aged 33-41	9
4	Female doctors aged 47-51	4

In a later publication, both authors reported that Mexican doctors develop a numbness of conscience in the face of these forms of violence within their professional field (Castro; Villanueva, 2018). We argue that this type of violence originates from the actors in the medical field itself and rests on the hierarchies that structure it. Therefore, it enjoys broad legitimacy both from those who carry it out (e.g., higher-ranking doctors) and from the same stakeholders who are subjected to it (e.g., lower-ranking students). Consequently, protests against abuse in medical training were almost nonexistent: students passively accepted the problem, acknowledging that "that is just the way things are."

The authors noted that, following the increase in insecurity that erupted in 2007 with the so-called war on drugs in Mexico, health personnel began to protest against other forms of violence outside their professional field (Castro; Villanueva, 2018), that is, it is performed by stakeholders external to the medical field. These forms of external violence include the kidnapping, murder, and extortion of doctors by organized crime, as well as other actions that cannot be adequately classified as violence but are perceived as such by the medical profession, for example, the legal prosecution of malpractice cases.

These protests saw the emergence of hashtags such as *#NiUnPasanteMás*, in 2013, related to the murder of medical interns performing social services in rural communities, and *#YoSoy17*, in 2014, related to the judicial detention of 16 doctors accused of medical negligence in Guadalajara. In 2015, *#YoTambiénMeDormí* emerged, where Mexican students and residents showed their support for a doctor criticized by a user for sleeping during her shift, although without questioning the underlying working conditions.

These protests culminated in a national strike on June 22, 2016, demanding safer working conditions and the decriminalization of medical practice, but without any mention of the internal violence perpetrated by stakeholders within the medical field. In that publication, the authors identified a "sociological ambivalence" in how doctors confront different forms of violence: they normalize internal violence while protesting against external violence. However, shortly after publishing these results, feminist protests began to emerge that would break this historical silence.

3. Protests within the medical field during the fourth feminist wave

The fourth feminist wave differs from previous waves because it uses a new language with its demands and relies on digital actions, especially on social media, with trends marked by feminist hashtags or "*femitags*" that emerge and can quickly mutate, overlap, or recede. Rovira (2018) says that the fourth wave is constituted by a pragmatic feminism, linked to the "*do it yourself*" hacker mode, or as hackfeminists declare, "*let's do it together*". This wave of international reach has local particularities. In Mexico, the first fourth-wave feminist mobilizations emerged in the broader context of the war on drugs, parallel to but not at that time linked to the medical union protests described above.

The rise in femicides and the impunity that accompanies them served as a spearhead for contemporary Mexican feminism. In 2015, women's protests began to multiply, importing the hashtag *#NiUnaMenos* from Argentina. A year later, the so-called "National Mobilization Against Macho Violence" was organized, identified with the hashtag *#VivasNosQueremos*. In this context, the "gender agency" (García-Guevara, 2021) of female students at several Mexican universities was ignited: femicides

that occurred within educational facilities, such as the murder of Lesvy in 2017 at the hands of her boyfriend on the UNAM campus, prompted students to openly denounce different forms of gender violence in the educational environment, creating mobilizations that escalated in the following years (Álvarez Enríquez, 2020).

As the feminist movement grew in Mexico, public protests by the medical profession against external violence faded. However, at the same time, internationally, female doctors began using social media to share their experiences of being women in a highly masculinized professional field. They created hashtags such as #WomenInMedicine and its Spanish counterpart #MujeresEnMedicina. Female surgeons created the hashtag #MeVeoComoCirujana and formed support groups such as @WomenSurgeons. In Mexico, the Facebook group Doctors Supporting Doctors was launched, with 48,300 Mexican female doctors currently participating. All these virtual actions allowed female doctors to share experiences, which reduced their social isolation and the feelings of loneliness they previously experienced (Espinoza-Portilla; Linares-Cabrera, 2020; Shillcutt; Silver, 2018). Feminist protest within the medical field was clearly an event originating outside the field, which permeated it. Within the field, those who promoted these protests were students or residents who structurally occupy a marginal or peripheral position within the field.

In October 2017, #MeToo went viral in the United States after actress Alyssa Milano used the hashtag in response to a New York Times report documenting Harvey Weinstein's sexual harassment and abuse of many women in Hollywood. This event sparked a social and cultural movement to address the problems of sexual harassment and gender discrimination in medicine (Lu et al., 2020). #MeToo empowered many women to identify and speak out about harassment, producing greater shifts in collective consciousness and specific norms than previous corporate policies had achieved over decades (Mainiero, 2020; Williamson et al., 2020). During the viralization of this hashtag, #MeTooMedicine emerged in the United States, and the "Time's Up Healthcare" movement was created to unite efforts among healthcare professionals (Choo et al., 2019).

While the start of the Mexican #MeToo movement did not have the scope of its American counterpart, it resurfaced a few months later, marking the beginning of what Rovira and Morales (2023) called the "Ides of March", a period between March 2019 and March 2020, that is, immediately before the outbreak of the COVID-19 pandemic. The "Ides" began with the escalated #MeToo in Mexico and the direct targeting of writers, musicians, journalists, academics, and doctors with the hashtag #MeTooMedicina. These virtual mobilizations created a growing transgressive conflict, culminating in March 2020 with the 8M march and the 9M strike, "On the 9th, no one moves".

Female university students played a central role in the "Ides of March". During this period, they organized marches, occupied academic facilities, and set up clotheslines denouncing the several forms of gender-based violence they experienced in the educational setting. Female doctors were no exception, as a general practitioner from Sinaloa recounts:

> "When the clothesline was held, many of the students here at my school spoke out. [...] Names of doctors came to light; one was the academic vice-principal, another taught classes, another was in clinical settings" (FG2).[1]

The use of feminist hashtags or "*femitags*" during the fourth wave has encouraged many young women without prior feminist activism to feel challenged and drawn to speak and act, thereby becoming protagonists of this new global wave of feminist mobilizations (Rovira Sancho, 2024). This also occurred within the medical field, as explained by a medical intern in social services in the State of Mexico:

> "Different movements have existed in my generation, particularly #MeToo. They have helped us talk about different situations we were experiencing and support each other much more, and speak out. It wasn't just about telling your best friend, "This happened to me". It was about knowing

1 In this section, we will identify the testimonies by the acronym "FG" (Focus Group) and the corresponding number according to Table 1 presented above.

> that you have the support of your entire generation. Even if you don't get along too much with one peer, you know they're going to be there for you. [...] We went on strike and we got moving." (FG1)
>
> For many, contemporary feminism has been a turning point, breaking with the normalization of gender violence they previously held. An epidemiologist from Morelos describes it: "It [the feminist movement] helped me understand what had happened to me, even though many years have passed since it happened. [...] It's as if the blindfold had been removed from my eyes" (FG3).

The online strategies of contemporary feminism have been instrumental in breaking the normalization of internal violence in the medical field. A pediatric endocrinologist from Mexico City explains:

> "I think social media is a major turning point, not only in terms of gender, but also in the workplace abuse of interns, trainees, and residents. [...] Social media has helped us realize that what if one person suffers, many suffer" (FG3).

The feminist movement denounced mechanisms that previously normalized internal violence in the medical field. For example, there was previously no consensus among the stakeholders involved about what acts could be considered violent (Ogden et al., 2005). Now, however, it has been said that there is an oversensitivity around what constitutes sexual harassment (Lamas, 2021). There used to be a tendency to view belittling, intimidation, and bullying as motivational tools in medical education (Rees; Monrouxe, 2011) that served to "build character" (Castro; Erviti, 2015), but now these practices are being questioned. It had also been identified that domestic violence was normalized through narratives that distorted the facts and cast doubt on the credibility and integrity of victims (Witte et al., 2006); now, in contrast, hashtags such as #YoSíTeCreo have managed to redistribute credibility in favor of those who report it (Guerrero MacManus, 2023). Likewise, it had been pointed out that another normalization mechanism was the lack of response by the authorities to the few complaints that existed (Castro; Villanueva, 2018), and now we have new institutional mechanisms to proceed in cases of gender violence (Fernández Altuna et al., 2024).

However, it is not that the protest within the field took root as part of an internal questioning of its patriarchal structures. Instead, it is part of a broader questioning of the patriarchal structures of Mexican society (and of current societies), by which female doctors (young students mostly) identify within their specific field (Medicine) patterns that they are also denouncing in other areas of their lives.

Therefore, the same did not occur in the case of other forms of internal violence in the medical field, specifically that related to mistreatment during the training of medical residents. As we will see below, it seems that the conjunction of some central characteristics of resident training, such as the precariousness of their professional and working conditions and the measures imposed by the health emergency, facilitated the reproduction of this event.

4. Precarious conditions and mistreatment of residents during the COVID-19 pandemic

In countries like Mexico, the severe structural flaws in the health system (Frenk; Gómez-Dantés, 2022) must be considered when studying how internal violence within the medical field and the dynamics imposed by the COVID-19 pandemic have been correlated. One of these structural features relates to the precarious forms that characterize the Mexican health system. This topic, however, has been addressed only indirectly in the existing literature. Some studies address the precariousness of the overall structure of the health system (Benhumea-González, 2019) or the job insecurity of health workers (Serván-Mori; Nigenda-López, 2024). However, surprisingly, we have not found any studies that analyze the precariousness of medical residents based on Standing's (2011) conceptual proposal. We maintain that "precariousness" is a

condition that facilitates the labor and gender abuse perpetrated against these professionals in training and that, therefore, it is necessary to consider their main attributes in order to look in directions hitherto ignored.

In a recent investigation, we documented the high proportion of medical residents who see their labor rights violated or even suffer violence during their training years (Castro et al, 2024). However, we need to go further. Resident doctors lack the seven forms of job security that Standing (2011) defines as typical of precariousness: they have no guarantee of full government employment, they lack protection against arbitrary dismissal, they suffer from deskilling and routine humiliation, they have no limits on work hours, including punitive guards and uncompensated night shifts, they are immersed in a punishment-based apprenticeship system, they receive a scholarship-salary without full employment benefits, and they do not have independent unions with the right to strike. This situation particularly affects first-year residents and, although it gradually improves, persists throughout their training.

The COVID-19 pandemic exacerbated the precarious conditions of medical residents. The uncertainty surrounding how to manage the epidemic was compounded by multiple emergency conditions, such as hospital restructuring, the need for many specialists to focus on caring for COVID patients, fear of the disease, and the self-disqualification of many specialists due to risk factors.

When the quarantine was established, the nascent social protest movements (feminists and doctors) were demobilized, and consequently, the emerging mechanisms of surveillance and accountability were dismantled. This created an even more favorable climate for the continued authoritarianism and mistreatment to which residents have historically been subjected.

The literature reports numerous studies on the stress and burnout experienced by medical staff during the pandemic (Shanafelt; Ripp; Trockel, 2020; Spiers et al., 2021), but without mentioning the authoritarianism and internal violence that characterize residency training. Few studies have focused on how the COVID-19 pandemic influenced the increase in several forms of mistreatment of medical residents. The topic is only marginally alluded to, mentioning, for example, that "tense relationships" between doctors significantly contributed to the development of anxiety and other mental illnesses (Dunning et al., 2022). One study in particular shows that discrimination toward those who contracted the disease was reported among neurosurgery residents, as well as sexual abuse and harassment against female residents (De la Cerda-Vargas et al., 2022).

In the interviews we conducted, it was clear that upon entering residencies, doctors were partially aware of the fragile position they were in when entering the field, which they tended to compensate for with the excitement and enthusiasm that this new stage of training generated. For example, in the two testimonies that follow, we can see clear allusions to several of the attributes that define precariousness, in the terms of Standing that we mentioned above: insufficient wages, excessive hours worked, degrading treatment, lack of union or trade representation, and an environment unfavorable to the most general rights of workers:

> "I entered a highly specialized hospital run by the Health Secretariat. You walk in, and they treat you as if they were doing you a favor. You, as a resident, are the one who really works and supports the healthcare system. In Mexico, 60% of public care is provided by some type of intern: intern, trainee, or resident. We burden the healthcare system. They give us a very low scholarship for the number of hours worked." (E4M)[2].

> The doctor in training... is never considered and only obtains representation through the chief resident, who is usually this individual who has all the power and glory. It is not a democratic issue; it is not something that the doctors in training choose, but rather something that the directors put there. So, there is no actual capacity for representation, but it functions instead as a repressive arm within the world of the doctor undergoing training (E2M).

2 In this section, we will identify the testimonies by the interview number to which they correspond and the letter M (male) or F (female).

As we mentioned above, first-year residents arrived at their facilities at the same time the public health emergency was declared. It is very revealing that, from day one, the pandemic acted as a "magnifying lens"; that is, as a situation that facilitated the reproduction of the authoritarian mechanisms by which residencies operate. One resident recounts that on his first day as an R1, he and another peer were assigned to write notes on COVID patients:

> "I remember the first note my colleague and I wrote: we started getting yelled at for our notes. They never told us how to write them... we saw that the notes the attending physicians wrote were three lines long (just things like) vital signs, whether he peed, whether he pooped, whether he ate, whether he was okay, whether he was unwell... They told us: 'You have that as an example.' They didn't tell us how, so we asked how (and they told us): 'Well, use the notes as an example.' We wrote much better notes than what we were seeing, it should be noted. Moreover, they started yelling at us: 'You don't know how to write notes, why the hell are you handing that in, this is wrong, let's see, calculate it, tell me what this is, how the hell don't you know if you're already a resident, you should have read it!' Well, it was my first day, (I was just thinking): Excuse me for not knowing anything about a totally new disease on my first day, about which absolutely everything is just being discovered." (E4M)

This coincidence between the start of the pandemic and the beginning of the school year for residents also served as a vehicle for the authoritarianism with which the early stages of medical specialization typically unfold. An additional dimension of uncertainty due to the COVID-19 pandemic was added to the uncertainty with which first-year residents typically experience their "teaching-learning" process, which resulted in a deteriorated precariousness with which they often experience this stage:

> "We arrive at six in the morning, they make us run instructions, and basically tell us that since we're so stupid, we can't run the instructions for COVID patients. They haven't given us a single class nor taught us anything. What we know about COVID, we've read on our own. We were still at a point where there were very few studies and little scientific evidence... However, we have no way of knowing if they don't inform us. Moreover, we're punished for it. One day, they tell you, 'They're not going to give you instructions because you're stupid'; the same resident the next day (changes his mind) and says, "Well, they're going to give you instructions. You'll pass them with your corresponding punishment." This sentence was repeated several times. They're already assuming that you're going to make mistakes from the start. So, they believe, why teach you when it's better to punish you?" (E4M).

With the hospital reconversion implemented as official policy to address the pandemic, there was also the mandate to dedicate as many medical professionals as possible to caring for COVID-19 patients. However, several testimonies from first-year residents indicate that the burden of care fell primarily on them. At the same time, senior doctors found ways to evade the responsibility of caring for these patients:

> "When the pandemic broke out, they obviously had us neurosurgeons come in. However, it was really just us R1s who went into the COVID ward; the higher-ranking residents didn't go in. I had the misfortune of getting COVID twice..." (E1M).

This hierarchical structure, based on the precariousness of residents, was the basis for decisions that in turn reproduced that inequality. For example, the tendency was to manage risk to the detriment of residents and in favor of higher-ranking doctors, the assigned:

> "...it was chaos and, obviously, the only ones who went in (to treat patients with COVID) were the first-year residents, because I never actually saw those assigned from other specialties inside the COVID area... the doctors who, in theory, were responsible for going in, no, they never stopped by there." (E1M).

In this context, the obligation to care for people with COVID was also used as an opportunity to punish residents. One of our respondents describes how having to enter the areas where these patients were kept was also a form of punishment. Feared by all, the COVID ward still entailed risks of infection and possibly death for those inside:

> "It became a COVID hospital. The first one admitted to COVID wasn't an internal medicine resident: it was me. I was punished and had to be there for eight hours. It was back when we knew nothing about the disease. I was the first resident admitted to COVID, as punishment (because I hadn't done some things right)" (E17M).

The punitive spirit was also expressed towards those residents who became infected and had to be on leave while they recovered:

> "I had COVID in December. They put me on sick leave for five weeks, and they were saying it was just me being lazy... I came back one day, and they put me on call when I was just coming out of convalescence. The next day, they kept me until midnight, and I ended up hospitalized again. I started having difficulty breathing again, trialgia, and so again they gave me another week (of sick leave). I ended up hospitalized there and at the Cardiology Institute, and they had to start me on hypertensives, antiarrhythmics, and things like that." (E14M).

The collected testimonies also include examples where the application of punishments is implemented together with conditions to hinder compliance or make it impossible to comply with those punishments:

> "...then he scolds me because I didn't do anything to the patient, and (as punishment he tells me that) I have to write two articles on genetic cancer phenotypes and, in two hours, I'm going to show my peers how to do it. So, I start looking for references, and he gets upset and tells me to take samples from all the patients on the floor. They just give you the runaround, no matter what, but they just give you nothing more than the runaround. Since you didn't manage it, he increases the punishment: "Well now, I'm going to add such and such article", to which I reply, "Doctor, I will be on duty". So, he says, "Well, tomorrow we'll see how you do it", and while you're there, he prevents you from working on it..." (E4M).

Finally, in this kind of "state of war" that was the pandemic emergency, even extreme cases of abuse against medical residents lost visibility and ceased to be of interest to the press because the only relevant information was related to COVID:

> "Initially, I asked my peers to support me and that we all go together to file the complaint, or that they support my human rights complaint. Because this was directed at me (but also at) my peer, because of all the sexual harassment she endured, I told her: "You are a compelling card because with the sexual harassment, right now, and the violence against women, with your testimony, we are all going to win here." She didn't want to; she was scared. However, at that time, my psychiatrist helped me contact a newspaper to tell my story, but the problem was that the newspapers were more interested in the COVID-19 situation. COVID-19 is what matters right now, and (they told me) that if it wasn't related to COVID, they really weren't that interested in publishing it." (E4M).

The fact that the resident interviewed invited a fellow resident to report the sexual harassment

she suffered as a strategy to rally support for her cause shows that, in the months leading up to the outbreak of the pandemic, the feminist struggle had managed to shake up the medical field by denormalizing this particular type of internal violence. This latest testimony also shows that this momentum slowed with the advent of the health emergency: in this new context, only COVID-related issues were relevant; protests against gender-based violence and other forms of domestic violence took a backseat. However, five years into the pandemic, we still observe a mismatch between the habits of healthcare professionals and the medical field's structures, as we will explain below.

5. Final reflection: Hysteresis of patriarchal habitus in the medical field and protest included in the residents' struggle

The data we have presented could be indicative of the emergence of a hysteresis event, which, as noted above, expresses the discrepancy between the group's habitus and the material conditions of the field to which it originally belonged. Hysteresis is primarily expressed in the case of feminist struggles within the field, but not in the case of the general reorganization of health services during the health emergency.

On the one hand, many doctors and managers continue to operate under frameworks that lead them to consider some practices (from sexist jokes to harassment) as "normal", which places them in a position of resistance or disbelief in the face of feminist demands. Female doctors and healthcare workers, on the other hand, having been socialized in this same field, may have had a habitus that led them to normalize or tolerate situations of violence; however, with social changes and the emergence of feminism, many are beginning to redefine these experiences as structural and unacceptable violence, which causes a break with their previous dispositions.

In other words, the medical field is showing signs of a hysteresis of the patriarchal habitus. Some indicators of this event are the emergence of intergenerational conflicts, in which doctors trained in previous decades may view these complaints as "exaggerated". At the same time, new generations perceive them as non-negotiable. Other data are more related to the mismatch between feminist demands and changes in the structures of the medical field. While universities have implemented reporting and sanctioning policies, hospital institutions have not been reformed as quickly. Furthermore, the hierarchical structure of the medical field itself prevents cultural changes from immediately translating into new practices within hospitals and universities. This has led to the emergence of tensions between new regulations and actual practices stemming from the field's inertia.

Instead, residents have traditionally occupied a subordinate, progressive learning role in the residency setting. However, during the pandemic, many were placed on the frontlines without the usual support, creating a crisis based on a lack of professional socialization in which residents had to adapt to an unprecedentedly difficult situation, generating tensions over who should make decisions and how.

Empirical evidence shows the existence of indicators of imbalances related to the health emergency, but whose durability we are unsure, for example: the conflict between hospital authorities and resident doctors (e.g., some experienced doctors may have perceived residents as poorly prepared, while residents may have felt abandoned and demanded in a context for which they were not trained); unprecedented forms of emotional exhaustion and burnout (the desynchronization between expectations and reality could have contributed to a greater sense of exhaustion and frustration among residents); and severe resident training shortcomings (e.g., during the COVID-19 pandemic, a large number of residents had to assume the obligation to focus on the care of this disease, regardless of the specialty they were pursuing). However, everything indicates that the medical field can process all these manifestations within the framework of what Tarrow (1998) called "contained protests".

Further research will be needed to determine whether we are facing a temporary hysteresis event (with a gradual return to "normal") or whether these are permanent changes. On the one hand, five years later, we see a persistent resistance among young doctors to continue normalizing the internal

gender violence they experience. Since the feminist movement comes from outside the medical field, it is understandable that women within the field continue to denounce this violence and question patriarchal patterns, resulting in the hysteresis event we mentioned. In contrast, residents' protests lack an external counterpart, as is the case with feminist protests, which explains why the pandemic has served as a vehicle to exacerbate the abuse and mistreatment that often occurs against residents, particularly first-year residents. We would then be faced with two different paths in which feminist struggles could propose lasting changes. At the same time, the struggles against other forms of violence in medical training could follow the traditional course of normalization.

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Contribution of the authors

Both authors conceived the argument of the article and contributed to writing and editing the manuscript. Castro's empirical and theoretical work served as the basis for Sections 4 and 5, while Villanueva's empirical and theoretical work informed Sections 2 and 3.

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