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Medical residency between practice and educational policy: the role of Abem's working group

Residência médica entre práticas e políticas educacionais: o papel do grupo de trabalho da Abem

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ABSTRACT

Introduction: Medical residency in Brazil is recognized as the preferred pathway for specialist training. Despite its relevance, research on the topic remains limited within the broader field of medical education. In response to current challenges, ABEM established a Medical Residency Working Group in 2024, which led to the development of the Association's First Medical Residency Forum.

Experience Report: Held during the 63rd COBEM, the Medical Residency Forum brought together participants in thematic groups to build objective-images around key pillars of residency training, such as access, mental health, evaluation, and governance, resulting in collectively validated proposals.

Discussion: Key challenges identified included unequal distribution of residency slots, resident burnout, program evaluation, and the strengthening of the CNRM. Policies like Pró-Residência, ENARE, and the Mais Médicos Program contributed partially to expanding access.

Conclusion: Despite progress in public policies for medical residency, structural challenges remain. The creation of a National System of Health Residencies is proposed as a strategy to enhance specialist training for the SUS. In this context, ABEM's working g roup stands as a vital space for reflection, scientific production, and support in shaping public policies.

Keywords: Internship and Residency; Education, Medical; Societies; Health Advocacy.

RESUMO

Introdução: *A residência médica (RM) no Brasil é reconhecida como forma preferencial na formação de especialistas. Apesar de sua relevância, ainda há pouca pesquisa sobre o tema no universo da produção acerca da educação médica. Diante dos desafios atuais, a Abem criou em 2024 um grupo de trabalho (GT) de RM que desenvolveu o I Fórum de Residência Médica.*

Relato de experiência: *O Fórum de Residência Médica, realizado durante o 63º Cobem, reuniu participantes em grupos temáticos para construir imagens-objetivo sobre eixos estruturantes da RM, como acesso, saúde mental, avaliação e governança, consolidando propostas validadas coletivamente.*

Discussão: *Destacaram-se desafios como a distribuição desigual de vagas, o adoecimento de residentes, a avaliação dos programas e o fortalecimento da CNRM. Políticas como o Pró-Residência, o Enare e o Programa Mais Médicos contribuíram parcialmente para ampliar o acesso.*

Conclusão: *Apesar dos avanços nas políticas públicas para a RM, persistem desafios estruturais. A criação de um Sistema Nacional de Residências em Saúde é proposta como estratégia para fortalecer a formação de especialistas no SUS. Nesse contexto, o GT da Abem se consolida como espaço essencial de reflexão, produção científica e apoio à formulação de políticas públicas.*

Palavras-chave: *Internato e Residência; Educação Médica; Associações Profissionais; Advocacia em Saúde.*

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INTRODUCTION

Medical residency (MR) originated in the United States in the late nineteenth century for the purpose of surgeon training. In Brazil, it was inaugurated in the 1940s, at healthcare units in Rio de Janeiro and São Paulo. However, it was only in 1977, upon the creation of the National Medical Residency Commission (CNRM)[1], that organisation of the programmes was assumed by the state.

In 1981, Law No. 6,932 was enacted, considered the most important for MR in the country[2]. This law establishes the nature of postgraduate courses, characterising them as in-service training, and creates the exclusive accreditation of this model for the CNRM[3].

Since the decree that created the CNRM, decisions within the scope of the commission that have repercussions for the country's entire MR programmes have been taken by a collegiate body made up of government sectors and medical organisations. The Brazilian Association of Medical Education (ABEM) has been a member of the CNRM since its foundation in 1977[4,5].

Recognised as a benchmark in specialist training, the MR has established itself as the gold standard in postgraduate health education[6]. Despite its widespread adoption and appreciation, there are still few systematic studies that rigorously assess the quality of this modality and the effects of organisational diversity between the different medical residency programmes (MRPs).

As an example of our scarce scientific production on MR, the Revista Brasileira de Educação Médica (RBEM, Brazil's leading journal on medical education and in circulation since 1978, has published only 112 articles directly related to residency since its creation. This equates to 4.61% of the 2,429 publications between 1978 and 2025, based data collected from the titles of RBEM publications available on the Scientific Electronic Library Online (SciELO). It is also worth noting that 81.25% of the publications in the RBEM on residency are concentrated in the last 15 years.

It would therefore appear that MR deserves more attention for scientific and political reflection, especially with the trend towards changes in undergraduate medical training in Brazil, characterised by the widespread opening of medical schools[7], a change in the profile of students accessing higher education[8], high levels of student debt[9] and the expansion of non residential postgraduate courses[10].

Medical specialist training in Brazil is subject to bottlenecks and inequitable distribution, justified even by specific public policies such as the recently created Agora tem Especialistas (Now there are Specialists) Programme[11]. There is also a trend identified in the latest national study into medical demographics (Demografia médica), which shows a certain degree of consensus among various sectors (government, medical organisations and medical education specialists) that MR is the main and most adequate strategy for training specialists. However, it still faces historical problems, such as excessive workloads, low pay and a discrepancy between the number of medical graduates (which has increased) and the disproportionate number of MR vacancies[10].

From this reality, the need arises to broaden the MR agenda within ABEM, and for this reason, based on workshops and meetings held between 2022 and 2023, an ABEM MR working group (WG) was created, with the aim of increasing visibility and political-scientific production within the organisation on a subject so dear to medical education. The MR WG was formalised in 2024 and since then it has produced reflections, contributions, positions and guidelines for Brazilian MR.

At the 2025 Brazilian Congress of Medical Education (COBEM), the 1st ABEM Medical Residency Forum was held, with the intention of producing summaries on the main aspects of MR. The aim of this article is to report on the construction and final product of this forum.

EXPERIENCE REPORT

The ABEM RM WG is made up of educators, students and managers who are members of the organisation and interested in discussing the subject. The organisational structure of the WGs at ABEM is relatively new, having been regulated as of March 2023 by the organisation's general regulations. The formation of thematic groups to deepen and produce studies on specific themes or strands of medical education[12]is, therefore, now an official procedure.

The organisation of the working group and its actions

In this most recent period, the initial milestone in ABEM's drive to intesify reflections on MR was the workshop "Medical residencies in Brazil: building an initial diagnosis and understanding ABEM's role", held in 2022 at COBEM in Foz de Iguaçu. At this meeting, the objectives were to list the central and structuring challenges facing MRs and to come up with action strategies for ABEM. To start the process, a word cloud was built from the following question: "What are the main challenges we need to face in order to build a quality, socially-referenced medical residency in Brazil?" (Figure 1).

This cloud guided the development of the workshop, in which the following aspects were highlighted: access, quantity and distribution of MR vacancies, regulation of the professional practice of medicine, training of preceptors, curriculum and assessment. A series of actions emerged from the workshop, such as the establishment and consolidation of the WG.

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Figure 1. Word cloud – "Medical residencies in Brazil" workshop.

Source: Prepared by the authors.

Over the subsequent years, the WG had the opportunity to contribute to the construction of the National Health Residency Policy (PNRS), to position itself in relation to the change in the composition of the CNRM in 2024 and to hold monthly online meetings on the theme in partnership with the Collaborative SIG in Medical Education of the Telemedicine University Network (RUTE).

Preparation and methodology of the Medical Residency Forum

In 2025, the first ABEM Medical Residency Forum was organised, with the aim of drawing up summaries of the structuring axes of MR, which were based on reflections from all the WG's previous productions.

The forum took place at the 63rd COBEM with no prior registration requirement, and 30 participants. In addition to an opening conference on "education through work", the participants were invited to work in small groups distributed at random, respecting the proportionality of residents and non-residents in each group. Among the participants were eight residents, four managers and 22 teachers/preceptors: 16 cisgender women and 14 cisgender men. The regional origin of the participants and their self-declared race/colour were not recorded. Each group had to construct a target image[13], i.e. a clear representation of an ideal scenario that they were trying to achieve within a certain aspect of the MR. The objective image should have characteristics such as clarity, being motivational, realistic, ambitious and consensual. Each of the aspects also received a set of trigger questions to facilitate debate and reflection (Table 1).

The work process began with the selection of a rapporteur from among the participants in the small group who would summarise and report on the discussion, thus producing the target image by recording it on a flipchart. The synthesis was subject to validation by consensus of the group's participants. Subsequently, all the group's productions were assessed in a plenary session attended by all the participants, and those not initially in that group proposed changes, validated or rejected the ideas in the synthesis. Consensus was the mediation strategy used, and ideas that were not validated by all the participants could not be included in the target images.

Table 1. Aspects and trigger questions for small groups.

- Aspect 1: Access to and retention in residency (universalisation, retention of specialists and completion of the medical course)	• What would a system look like in which all medical graduates had guaranteed access to a residency place? • What would be the fair and transparent criteria for the distribution of residency places? • What are the proposals for creating retention policies for residents?
- Aspect 2: Mental health in the residency	• What are the causes of illness in medical residency? • What strategies can be used to mitigate or change this situation?
- Aspect 3: Evaluation of residents and medical residency programmes	• How should we think about the evaluation and self-assessment criteria for medical residencies? What criteria should there be? • What are the evaluation strategies for residents? • What is the role of the Progress Test?
- Aspect 4: Strengthening residency control bodies and mechanisms	• Has the way residences are organised in Brazil been effective? • What is the role of the government and the bodies that organise residencies (National and State Medical Residency Commissions)? • How can this process be strengthened?

Source: Prepared by the authors.

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Although this forum strategy favours consensus as a strategy for mediation and balance of different voices in the groups, significant restrictions are met, such as the challenge of the representativeness of a single report, the possibility of consensus concealing probable disagreements at the time of the discussions, the limited time for negotiation, the limit on the number of participants and disproportion between the categories. It is also noteworthy that, as this is an open space – in this case, prior registration was not required for participating in a broad event to discuss medical education – there is a possible bias in the representativeness of the group, favouring participants who are engaged in the subject or already aligned with the residency discussion agenda.

Final product of the small groups validated by the forum

Working in small groups allowed for a more in-depth discussion of the aspects and the structuring of ideas based on reports so that they could be validated at the end with all the forum participants. Below is the final set of target images constructed at the 1st Medical Residency Forum.

Aspect 1
Access to and retention in residency (universalisation, retention of specialists and completion of the medical course)

We need to move towards a model in which access to residency is universal, fair and connected to the real needs of the country. Every medical graduate should be able to find a guaranteed residency place, in a model that recognises residency as an essential stage of medical training, rather than something restricted and optional.

Accordingly, the number of places needs to keep pace with the number of graduates, with strategic and equitable distribution, mediated by public policies that articulate local demands with the supply of places. The National Residency Examination (ENARE) could be consolidated as a single national selection programme, promoting fairness and transparency, with clear and democratic criteria for entry and allocation.

The MR needs to become part of a structured career plan, with retention policies that include financial incentives, supplementary grants according to territory and speciality, as well as better working conditions. Residents should be encouraged to work in lagging regions through retention strategies not based purely on obligation – involving support, recognition and the prospect of career growth.

Medical schools must take an active role in managing vacancies, integrating their assessment processes into the admission model and promoting greater social justice through affirmative action. There should be greater integration and dialogue, via the CNRM, between national, state and municipal managers, in order to strengthen networked training.

Against such a backdrop, access to MR ceases to be an exclusionary funnel and becomes a solid bridge between training and action, with a more intense role for the state through its collegiate bodies and the action of all federal entities in access regulation.

Aspect 2
Mental health in medical residency

A future in which MRPs recognise and value mental health as an essential pillar of professional training. Residents must be welcomed from day one, with support for geographical, emotional and financial adaptation – including easier access to assistance and retention, such as housing and transport.

Therefore, the residency needs to be structured in such a way as to strengthen the role of the resident in the management of the programme, with open and safe channels for listening and reporting, firmly confronting structural oppressions such as racism, LGBTQIAPN+phobia, bullying and sexual harassment. Institutional flows must be clear, accessible and backed up by manuals that guide behaviour and guarantee protection.

The programmes' working hours need to be compatible with life: they need to allow a work-study-personal life balance, including motherhood, family care and rest. The residency grant needs to be reviewed and adjusted to the reality of the medical labour market, preventing residency from becoming a financial burden.

Mental health must be promoted through specific lines of care, reception groups and individualised monitoring. Programmes need to perform routine assessments and entry profiles for residents. Preceptors need to be valued with incentives and ongoing training, preparing them to exercise their role as educators with responsibility and empathy.

Finally, the State Medical Residency Commissions (CEREM) must be strengthened and reflections on resident mental health must be institutionalised in regulatory and monitoring bodies, ensuring that programmes are adapted to a scenario that can value resident care.

Aspect 3
Evaluation of residents and medical residency programmes

The MR needs to value evaluation as an instrument of care and improvement – not as punishment or exclusion. A model in which residents, preceptors and programmes are continuously and transparently assessed, based on criteria built

collectively and aligned to the real in-service practices. Each MR must have a structured evaluation plan that includes:

- Self-assessment of the programmes, actively listening to residents, preceptors, managers and SUS users.
- Clear and public criteria that take into account not only technical performance, but also ethical, relational and pedagogical aspects carried out in a timely and permanent manner.
- Diverse instruments, such as, for example, reflective portfolios, formative evaluations, structured feedbacks, and care quality indicators.

The Progress Test can be consolidated as a national tool for longitudinal monitoring of training, allowing residents, programmes and managers to understand the development of knowledge over time. It must be built on reliable practices, with the participation of scientific societies and the residents themselves.

Self-assessments need to include general criteria for all programmes, such as: infrastructure, contracts with practice settings, pedagogical planning, evaluation, support for residents and preceptors, policy for the development and career of preceptors, social control and compliance with CNRM standards and guidelines, as well as specific criteria for each speciality and field of practice.

Evaluation must move away from being a vertical control mechanism and become a horizontal, ethical and transformative process – capable of strengthening residency training and protecting professionals and users.

Aspect 4
Strengthening residency control bodies and mechanisms

We propose a MR system in Brazil that is coordinated by bodies that are strengthened, articulated and committed to the quality of training, equity in access and active listening to the various agents involved. A model in which the CNRM, CEREM and PRM act with autonomy, representativeness and technical capacity to ensure that each residency programme operates with social commitment.

In this scenario, regulatory bodies can observe the diversity of programmes and local realities, protecting them from corporate interests and ensuring that residency training is geared towards the needs of the SUS. Public policies must be built on the basis of social indicators, respecting territories and promoting provision strategies that encourage the work of specialists in historically underserved regions.

The competency matrix is being reformulated on the basis of effective practices, in dialogue with the realities of the services, beyond the scope of speciality professional associations. Training needs to be continuous, with reliable and participatory evaluation tools – such as the Progress Test – that monitor development from the start of the programme and allow for pedagogical adjustments along the way.

The organisation of the MR must stop being fragmented and become integrated, transparent and geared towards strengthening the SUS. Control mechanisms become instruments of care rather than punishment, promoting listening to communities, valuing professionals and building pedagogical projects committed to the health system.

DISCUSSION

The organisation of a Residency Forum emerged from the idea of "first steps", in other words, an initial space for proposing contributions to MR discussions that is provisional in nature and needs to be revisited in the process of reflecting on public policies.

Among the target images identified by the Residency Forum, some aspects require special attention, in particular the discussion of access to MR in the country, as well as its distribution and universalisation. It's important to note that over the last few decades, strategies have been created with a view to interfering with the inequitable distribution of MR vacancies across Brazil.

The National Programme to Support the Training of Medical Specialists in Strategic Areas (Pró-Residência) was and continues to be an instrument in this regard. There are indications that it has fulfilled this role, although there is still a strong concentration of specialists in the South and Southeast regions of the country. Although important, its effects are considered to be of low magnitude given the structuring conditions of multiple causes on which Pró-Residência is unable to act, such as the very concentration of the supply of health services and larger hospital units in the South and Southeast regions, and the decentralised selection for residency, which is beginning to be attenuated by the rise of ENARE as a national selection test[14,15].

From this perspective, the ENARE also needs to be highlighted as a policy to induce decentralisation and fill vacant places. The exam has enabled cost reductions in registration for the selection process and the opportunity to select vacancies in MRPs in remote locations from the candidate's home. In 2025, it offered 6,894 MR vacancies in 1,806 MRPs[16].

Another public policy with a major impact on the MR was the More Doctors Programme (Programa Mais Médicos). The programme initially made residency in family and community medicine (FCM) compulsory as a prerequisite for most of the MRPs and the institution of a specific annual assessment in

residency, and pointed the way to universalised vacancies[17]. Although it has been gutted over the years, to the point of losing a large part of its most structuring elements, it has also resulted in the expansion of vacancies in vulnerable and priority regions, while challenges remain for their further expansion and occupation[17-19].

It seems, therefore, that public policies have been able to mitigate, albeit to a limited extent, the distribution of MR in the country and guarantee universal access. In a study made available by the Rio de Janeiro Council of Municipal Health Secretariats (COSEMS), of the possible correlations of doctor distribution in the state, when comparing population, GDP per capita, available beds and supplementary health coverage, it was found that the greater the coverage of private health plans and insurance, the greater the availability of doctors[20].

The history of self-regulation in medicine combined with the fact that the state does not play a role in planning, controlling and regulating the profession can reduce the availability of professionals for the SUS, as well as affecting the expansion and distribution of residency places, thus acting as a structural limitation. The medical profession plays an key role in defining how regulatory processes are conducted and disputes this role with the state, a reality which is not exclusive to Brazil. Part of the medical profession does not respond adequately to the broad socio-cultural context, tending to act only when there is state interference[21,22].

Another aspect that should be highlighted, and which was echoed in the discussions at the Residency Forum, relates to the process of burnout and illness among resident doctors. The concern for mental health stems from evidence of a training model that has been shown to incur high rates of anxiety, depression, burnout, among other health issues[23-26].

There are illness factors related to personal characteristics, the training process and the practice setting, with women and black people being more affected. Poor teaching support, a heavy workload, sleep deprivation and precarious working conditions represent some of the triggers[27]. The mental health of the resident needs to be reflected in the light of the protection of the professional who is part of a learning process, but also reflect the safety of the patient. Sick professionals are more likely to make mistakes, as in the emblematic case of Libby Zion in the United States, which led to extensive reforms in the MR training process[28]. It is therefore essential to build psychological and pedagogical support strategies, to move forward with a national agenda to reduce workloads and increase financial reward, and to invest in the qualification of supervision and preceptorship.

The evaluation of residents and the MR must also reflect these aspects related to the care and improvement of programmes and professionals. In 2023, the CNRM published a resolution on the assessment of resident doctors. This resolution calls for systematic formative and summative assessments, based on cognitive domains, skills and attitudes, with structured feedback, as well as encouraging other assessment strategies, such as the Progress Test and the use of entrustable professional activities to certify level progression[29].

Achieving the assessment targets set out in this resolution, however, is not easy. MRPs need to be monitored so that these targets are implemented. In this sense, speciality professional associations can be entities that help and strengthen the quality of MRPs[30]. In order to do so, they must be guided by the CNRM general guidelines, aligned with the need to combat inequalities, as already mentioned, and an assessment that has the care of the resident-patient binomial at the centre of the process.

Finally, MRPs need to be assessed on the basis of characteristics common to all programmes and characteristics specific to each speciality. Infrastructure, contractual agreements with practice settings, pedagogical planning, evaluation strategies, social control, support for the resident and preceptor, and development and career policies for preceptors were the aspects pointed out by forum participants as central points in a MRP evaluation.

The establishment of the CNRM was a fundamental stage in the regulation of residency programmes and brought historic advances, but there remain gaps in this process. It is essential to strengthen the full functioning of the CNRM and CEREM, so as to enable constant monitoring and evaluation of MRPs. The role of the states and municipalities in organising the MR[31]is still poorly regulated.

The strengthening of the CNRM's budgetary, technical and political infrastructure was also discussed at the forum. Without the ability to reach out to the states and municipalities and maintain a strong dialogue with the MRPs, it will be more difficult for resolutions, evaluations and quality processes to be implemented and monitored.

The proposals raised by the forum as an initial discussion are still in the conceptual field, and there will be a need for progress in reflecting clear operational mechanisms and governance strategies for the realisation of actions that required prioritisation by common agreement between the federative entities.

FINAL CONSIDERATIONS

In the reflections held at the Residency Forum, it was possible to identify advances in terms of public policies for MR in recent years. A significant part of the challenges remain, as can be seen from the experiences of the actors who were

involved in the activity. To tackle them, it will be necessary to conceive formulations and gather even deeper discussions and reflections on the role of the state and service organisations in consolidating the medical residency.

One of the paths identified, which needs to be better evaluated and studied for effective validation and organisation, would be the creation of a National System of Health Residencies, with a view to making progress in terms of quality and specialist training.

The contributions made at this forum still need to be discussed in the light of the PNRS, which at the time of writing had not yet been published after a long stage of construction and public consultation.

As an experience report, this study has limitations inherent to its format. As a description of experiences and processes, it favours narrative over systematic analysis, which reduces the possibility of generalising the results to other contexts. Furthermore, the conclusions depend heavily on the perception of the participants involved, which can introduce biases and limit the diversity of perspectives. Finally, the contributions are provisional in nature, representing "first steps" that need to be revisited and expanded in new spaces for reflection and research, which reinforces the exploratory and non-conclusive nature of the study.

For this reason, the ABEM MRI WG has become a fundamental space to continue reflecting, building consensus and paths forward, as well as promoting scientific production on MR in order to support the Brazilian state's actions, subsidising the construction of MR policies aligned with the needs of the SUS.

CONTRIBUTION OF THE AUTHORS

André Ferreira de Abreu Jr.: Conceptualization; Investigation; Methodology; Project administration; Writing – original draft; Writing – review & editing. Djerlly Marques Araújo: Conceptualization; Investigation; Methodology; Project administration; Writing – original draft; Writing – review & editing. Douglas Vinícius Reis: Conceptualization; Investigation; Methodology; Project administration; Writing – original draft; Writing – review & editing. Luiza Gomes Dantas: Conceptualization; Investigation; Methodology; Project administration; Writing – original draft; Writing – review & editing. Iago Ribeiro: Conceptualization; Investigation; Methodology; Project administration; Writing – original draft; Writing – review & editing. Vinícius Santos: Conceptualization; Investigation; Methodology; Project administration; Writing – original draft; Writing – review & editing. Matheus Gama: Conceptualization; Investigation; Methodology; Project administration; Writing – original draft; Writing – review & editing.

CONFLICT OF INTEREST

We declare no conflict of interest.

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DECLARATION OF DATA AVAILABILITY

Research data is available in the body of the document.

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