The Medical Residency System in Argentina: History, Current Challenges, and Future Directions

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Since its formal establishment in 1944, with the initiation of the first medical residency under the Chair of Semiotics at the Hospital de Clínicas in Buenos Aires, the medical residency system has been a cornerstone in the training of specialists in Argentina[1]. Over more than seven decades, this model has evolved under the influence of healthcare dynamics and public health policies, consolidating its legitimacy as a postgraduate specialization mechanism while gradually losing its university influence and, consequently, the continuity between undergraduate education and specialized professional practice[2].

HISTORY AND CONSOLIDATION

Over the years, various institutional actors have promoted criteria for regulation, supervision, and operational standards. However, expansion has been marked by a strong concentration in the public healthcare sector, at both the national and provincial levels, with a lower participation from universities, the private sector, and municipal institutions. This expansion, particularly in the last 15 years, has been characterized by heterogeneity in training quality, integration between teaching and patient care, and working conditions[3].

An important component of residency policy was the creation of a quality assurance system and the implementation of the *National Unified Examination* (*Examen Único Nacional*), conceived as a standardized evaluation tool for selecting applicants. Although not all jurisdictions initially adopted it in the same way, by 2011, it had become a key instrument for ensuring equity and standardization[3]. Nevertheless, tensions remain: some candidates argue that it favors theoretical knowledge over clinical competencies, while others criticize the excessive weight given to the test compared with previous training trajectories. The recent crisis involving alleged leaks and fraud has highlighted the vulnerability of the selection system and the need for more robust mechanisms[4]. To date, a decision has been made to dismantle the unified national examination and return to provincial examinations. This move relinquishes the national government's role in harmonizing standards across districts in a federal country and in planning the health workforce, potentially deepening existing disparities.

When comparing our system with those in other parts of the world, we find both similarities and differences. Regarding admission, some countries, such as Mexico and Spain, have unified examinations similar to Argentina's national one. In the United States and Europe, residency training is embedded within a regulated system of postgraduate education, defined by structured curricula, ongoing supervision, and rigorous institutional accreditation processes that uphold consistent standards of quality[6]. This concept of postgraduate education linked to universities –though not always mandatory– is widespread across most countries, including our neighbors, which makes Argentina's health system –based residency model somewhat of an exception. This helps explain why, despite the existence of a quality assurance system regulated by the Ministry of Health, its sustainability remains complex due to the lack of specific funding, and its articulation with the system of the National Commission for University Evaluation and Accreditation (CONEAU) is also challenging, despite various efforts to bridge both spheres.

FACTORS INFLUENCING THE CURRENT STATE OF RESIDENCY PROGRAMS

Beyond these regulatory particularities, the motivations of medical graduates to pursue –or not

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pursue– a residency are multiple, involving both the choice of specialty and the institution where they wish to train. Various factors contribute to a perceived sense of risk in selecting a residency program, including remuneration, institutional reputation, program structure, job satisfaction, geographic location, and educational opportunities[7]. Among the main barriers are low pay, excessive workload, lack of full labor rights, and the unequal geographical distribution of programs[8]. Added to this is the appeal of immediate employment opportunities outside the formal residency system, particularly in a context of economic crisis. A growing and increasingly relevant aspect is the expanding role of migrant professionals. Several recent studies indicate that nearly 23% of candidates for the national examination come from other countries—a figure that continues to rise[9]. While this phenomenon helps sustain the supply of professionals in shortage areas, it also raises questions about the long-term retention of these practitioners after training and the policies needed to encourage them to remain in the country.

The COVID-19 pandemic further exposed the fragility of the system. A multicenter study conducted in Argentina revealed that 42% of residents performed tasks outside their specialty, and most experienced a reduction in training opportunities—especially in surgical specialties[10]. At the same time, negative effects were observed on residents' mental health and quality of life, along with a weakening of the educational climate. These findings underscore the need to strengthen supervision, learning environments, and well-being policies within residency programs.

WHERE RESIDENCY PROGRAMS SHOULD BE HEADING

To ensure that residency programs continue to play a strategic role in the training of the health workforce, progress must be made along several key lines:

1. Territorial equity and critical specialties: implement incentive policies for residencies in underserved regions and in specialties facing a shortage of professionals.

2. University–health system integration: strengthen the active involvement of universities in both the training and supervision of residents.

3. Regulation and standardization: develop national core curricula for each specialty with university participation, and establish joint accreditation frameworks between the health and education sectors.

4. Educational innovation: broaden the adoption of competency-based training methods, simulation, mentoring, and problem-based learning.

5. Enhanced national examination: ensure transparency and technological safeguards while incorporating assessment criteria aligned with the graduate profile defined in undergraduate standards, thereby supporting strategic workforce planning.

6. Working conditions: improve remuneration, guarantee adequate rest periods, and ensure the recognition of full labor rights.

CONCLUSION

Argentina's residency system for health professionals has a longstanding tradition that positions it as the backbone of specialist training. However, it currently faces legitimacy and sustainability issues. Rethinking its future requires the integration of policies that promote equity, regulatory coherence, educational innovation, and decent working conditions. Only through such reforms can residency programs fulfill their dual mission: to secure a high-quality specialist workforce and to strengthen the Argentine health system as a whole.

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