



Professional transitions in medicine – switching medical specialties

Alterações de rota na medicina – reescolhendo a especialidade médica¹

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Abstract

Professional transitions in Medicine are particularly difficult for physicians due to the costs and duration of medical education. This study sought to understand the experiences of physicians who have changed specialties, analyzing motivations and meanings underlying such transition. This is a qualitative study conducted with data collected by interviews with physicians that switched specialties. Our results indicate that excessive workload and lifestyle were the main motivations for change. Regardless of criticism, the physicians interviewed showed great satisfaction with the transition. Switching the medical specialty seems to be a positive individual strategy to deal with dissatisfaction. However, in doing so, one should evaluate the lack of meaning for both the individual and medical practices.

Keywords: Career Choice; Specialization; Medical Education.

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Resumo

Transições profissionais na Medicina são particularmente difíceis para os médicos, devido ao tempo e ao custo da formação. O objetivo deste trabalho é compreender as experiências de médicos que reescolheram a sua especialidade, investigando motivação e as implicações da mudança. O método adotado foi um estudo qualitativo com entrevistas de profissionais que mudaram de especialidade. A pesquisa mostrou que entre os motivos para a mudança de especialidade estão a insatisfação com a área, mesmo com pouco tempo de prática, o estresse do cotidiano profissional e o estilo de vida. Apesar das críticas recebidas, os entrevistados demonstraram grande satisfação com a mudança. Como estratégia individual para lidar com a insatisfação, a mudança parece positiva. Entretanto, é importante refletir sobre o risco de vazio de significações para o sujeito e as práticas médicas.

Palavras-chave: Escolha da Profissão; Especialização; Educação Médica.

Introduction

Transitions and changes are part of life and require no small amount of psychic work (Uvaldo, 2010). In the professional field, they imply breaking not only with what has already been built in the career, but sometimes also with values, models, established relationships, and even family ties (Soares, 2002).

Although inconstancy, disruption and discontinuity are common features of contemporary career paths (Ribeiro, 2011), people who go through transition situations are emotionally impacted, with symptoms of *burnout*, a sense of fear and incompetence (Lima, 2003). Career changes can be understood as defeat and social demands can be high for those who switch careers (Uvaldo, 2010; Moura and Menezes, 2004)

In the medical profession, changing the professional route can take on an even greater dimension depending on the investment time in training, the cost involved and the social expectations related to this professional category.

Medicine is part of a professional scenario with a huge range of work possibilities due to its various specialties. In this choice, the professional is faced with a multiplicity of factors that involve their personal interests, personality, professional stereotypes, work styles, work opportunities and even aspects related to gender (Burack et al., 1997; Goldacre, Goldacre and Lambert, 2012; Lambert et al., 2003). Because of this, Bellodi (2001) emphasizes that talking about the process of choosing a medical specialty is more than a difficult task, it is a complex task.

This process and its outcome are not always smooth and satisfactory for the subjects, generating negative repercussions for both the physician and his patients. However, there are few studies on the process of career re-election or of giving up the medical specialty. They value more the reasons that lead to the choice, with few investigations into the rejection by a given area (Van der Horst et al., 2010).

Factors such as time for family life, possibilities for promotion, type of patient seen, self-assessment of skills/attitudes and personality characteristics are considered by physicians when they change

area. A study carried out in the United Kingdom (Gale and Grant, 2002) indicated that a third of English physicians changed their specialty after the choice made at the end of graduation, with primary care specialties being the most abandoned due to remuneration and lifestyle.

Goldacre, Goldacre and Lambert (2012) identify that quality of life is more important when giving up an area than competitiveness, complexity, a stressful workplace and little training. Lambert et al. (2003) highlight interpersonal relationships at work as factors that lead to the rejection of a specialty. In Brazil, manageable lifestyle, financial reasons, autonomy and personal time, in addition to employment opportunity, are also important factors in the choice or rejection of some areas (Souza et al., 2015; Corsi et al., 2014; Sousa, Silva and Caldas, 2014).

The importance of the subject also has repercussions on Public Health, helping to understand how doctors are distributed (Souza et al., 2015). Some authors claim that there is a trend towards a decrease in the search for the career of general practitioners and an increase in interest in areas such as dermatology, anesthesiology, radiology, and emergency care (Cruz et al., 2010).

Although there are no studies on medical specialty re-selection in Brazil, a recent survey published by the Federal Council of Medicine (Scheffer, Cassenote and Biancarelli, 2015) shows that 53% of Brazilian physicians have one or more specialties. This result, according to the researchers, reveals there is mobility between areas throughout professional life, probably based on personal interests and work opportunities, and that medical specialty is a flexible element in the professional life of many Brazilian physicians.

The theme of professional transition within medicine has emerged in other communication spaces dedicated to the professional trajectory of physicians, such as the BMJ Careers website (2013)², in which reports from professionals who experienced exchanges of specialties highlight the anguish experienced in the process (Ayre, 2013).

Considering that career changes promote changes in the subjectivity of subjects, in addition to the implications for the composition of the workforce, this study seeks to understand the experiences of physicians who switched specialties, investigating their motivations and the meaning of this change in their professional trajectories and life.

Method

Design

The study option was for a qualitative and exploratory approach, which would allow for apprehending the meanings for the subjects of the experiences lived in the process of switching medical specialties.

Qualitative research “involves empathy to the actors’ motives, intentions and projects, from which actions, structures and relationships become significant” (Minayo and Sanches, 1993), which is why this method was adopted in this study.

Subjects

Physicians who picked a new specialty and met the following criteria participated in the study: completion of a first degree (medical residency or specialization) in a certain medical area; working for at least one year in this area and migrating to another medical area, through a new specialization or medical residency. Individuals who changed their practices through subspecialties or who did not work in the area and changed areas while still in residence were not included. The classification of medical specialties used as a criterion for definition was established by the Federal Council of Medicine in 2017.

Participants were recruited electronically, using the researcher’s social network (Facebook). From the first indications, the formation of a group of doctors who changed their specialty and knew others in the same situation began, adopting the *snowball* strategy (Turato, 2003). To obtain a greater number

2 BMJ CAREERS, Home. [SI]: 2013. Available at: <<http://careers.bmj.com/careers>>. Accessed in: Mar. 2nd, 2016.

of nominations, the research was also published in several directories of universities and medical schools in São Paulo.

The group of respondents was composed of 18 doctors, aged between 33 and 64 years, with a predominance of women (13/18). The longest-trained physician graduated in 1975 and the most recent in 2007. Most respondents studied at public universities.

Instruments

In-depth interviews were conducted to collect personal testimonies about the professional trajectory, their motivations for change and the implications derived from them. The interviews were conducted by a single interviewer, in person, recorded with consent and later transcribed.

A script was created with questions that stimulated reflection on the process of re-choosing the specialty: (1) Talk about your choice for medicine and how the process of choosing your first specialty was; (2) What reasons led you to change specialty?; (3) Tell us about the process of choosing the second specialty; (4) Were there any difficulties in this re-choice?; (5) How is your current practice going?

The names of the participants were preserved and it was decided to identify them using the letter E (Interviewee), plus a number (according to the order of the interviews carried out), followed by the first specialty and specialty of re-choice. All interviews were preceded by filling out the informed consent form and explaining the research objectives and methods.

Data analysis

For the analysis of interviews, the technique of content analysis was used (Bardin, 1977), seeking the nuclei of meaning (Minayo; Sanches, 1993) present in the interviewees' reports. Clippings were organized by approximation of themes, establishing categories that grouped similar elements, allowing the discussion of the most relevant data.

Results

The analysis of interviews showed diversities and singularities, but also similarities and convergences

in the reports of physicians who switched their specialties. The following themes were highlighted: (1) Choosing to be a doctor; (2) The first specialty; (3) The change and its reasons; (4) The transition and the after.

Choosing to be a doctor

In general, the interviewees began their report expressing some difficulty in stating the reasons for choosing medicine. Some said they did not know such reason or used phrases like "I always wanted it" or "since always".

It was something I always wanted. It was a dream. There were no physicians in my family, but it was something I chose because I really liked it. (E14, from Pediatrics to Nuclear Medicine)

The classic reasons for choosing medicine, alone or intertwined, were present in the statements: vocation, desire to help others, taste for science, intellectual challenge and professional prestige. Some mentioned the desire to achieve greater social status and remuneration in relation to their families of origin.

I've always been a fighter, I always need to read more than once but I'm always very persistent, and my brother was very smart. Everyone said he was going to do medicine and he didn't want to. Then I saw my opportunity to shine, right? (E10, from Pulmonology to Radiology).

I had a very difficult childhood, from a financial point of view. But my father always thought we had to be a doctor, it was something very important for him. I kind of wanted to resolve my dad's frustration. (E15, from Pulmonology to Preventive Medicine)

The family, as one can observe in the previous reports, appeared frequently in the reports. All interviewees, without exception, alluded to it, either following tradition or inaugurating this role in family history.

You know, my whole family are doctors, since my grandfather. He was the first doctor in the

family, he was always an example for all of us in the family. My uncles studied medicine, my father studied medicine and it turns out that you are influenced in any way, there is no way. (E11, from Rheumatology to ICU)

I don't have a medical family, no one in the family is a doctor. But I've always wanted to, I feel good about helping others. (E7, from Surgery to Homeopathy)

There were no doctors in the family and I liked the area of biology a lot; when I was in high school we went to USP, I liked the atmosphere, but it wasn't anything about wanting to help people, this came later. (E6, from Family Medicine to Geriatrics)

One of the interviewees related his desire to be a doctor with a process of illness in childhood, when the relief of suffering was decisive in influencing his choice:

I remember that, since I was a kid, I came to the hospital so much, I was a sick child, according to my mother. I was always sick. (E2, from Pediatrics to Anesthesiology)

The first specialty

The course and its experiences were presented by all respondents as an important influencing factor in choosing the specialty. Some subjects, due to their content and quality, led to interest in a certain area. At other times, teachers acted as inspirational or supportive role models.

I went to do a surgical technique course and the chair holder said: you are very skilled, what are you going to do? I think I'm going to do oncology, I replied. And he: you're going to surgery, I'm going to train you! (E18, from Surgery to ICU)

During graduation, most interviewees thought about becoming a doctor within the large and traditional areas of medicine, such as clinical practice, surgery or pediatrics.

When I finished, I only had these four options: surgery, clinic, gynecology or pediatrics. Pediatrics - no way, I have no patience with children. The clinic, I didn't see myself talking to this point to become a clinic. Gynecology, I liked the surgical part, but I never liked the obstetrics part. So surgery got interesting. (E3, from Surgery to Occupational Medicine)

When choosing the first specialty, patient characteristics and type of practice were frequently mentioned by the interviewees. Personality appears in some reports, especially when choosing surgery.

I always liked critical patients, if you give me a different patient I get a little irritated. I prefer critical patients, I think you think more, intervene more, you can interact more with the patient. (E2, from Pediatrics to Anesthesiology)

I really liked the surgical part of medicine, I dreamed of doing major surgeries and being a "super surgeon" since I was little. I had a surgeon's figure. It was unthinkable to practice medicine, be a doctor, and not operate. (E7, from Surgery to Homeopathy)

Few expressed a choice of the first specialty based on financial factors or the labor market, but a comfortable choice, derived from family influence, was reported. And only one respondent stated that it was a choice derived from a single approval in the residency selection processes he participated.

Change and its reasons

Many interviewees showed signs of dissatisfaction with the choice made during their medical residency. The organization of work, whether due to overload or bureaucracy, led to questions about the initial choice. Hierarchical work relationships and emotional exhaustion also contributed to dissatisfaction and review of the choice.

The pediatric residency was a discovery of what it means to be a pediatrician outside the academic

world. I started to live with the day-to-day part: the shifts, arriving at the emergency room and having 300 children waiting, a stressed mother, screaming, crying, unexpected things. That displeased me a lot, because my internal rhythm is different. (E1, from Pediatrics to Psychiatry)

Until I got in, I only thought about the day I was going to be a surgery resident. My dream was the first day of residency: I would spend all day in the hospital, I would operate all day, I would do this and that. Then, at the beginning I said: is this it?! Is it being scolded, looking for an exam, requesting an exam, crying on the ultrasound to be able to do it, is that what it means to be a resident? I'm not enjoying this game anymore! (E18, from Surgery to ICU)

When already in the world of work, in the post-residence, the experiences of dissatisfaction, intolerance and frustration with what they were doing deepened and descriptions such as feeling unhappy and “couldn't take it anymore” were very present.

When I started treating patients in the office, I was disappointed with the results. I read articles, did the same thing, and the patients didn't get better. I also started to be disappointed with the therapy. (E10, from Pulmonology to Radiology).

The physical fatigue, stress, the family, there you dealt with health insurance patients, privately and the resident did everything, sometimes we were the only ones who put our hands on the patient, so I said: I don't want this for me. I was worn out. (E14, from Pediatrics to Nuclear Medicine)

Few respondents said the change occurred without strong dissatisfaction with the first specialty. Among these, some said their interests had changed, others that they were already thinking of the first area as a transition. There were those who incorporated their previous specialty into their trajectory, even though they changed area.

It was never a “I'm in pediatrics, but I hate pediatrics”. It was never a problem to be a pediatrician. (E12, from Pediatrics to Psychiatry)

I felt professionally fulfilled, I was successful, I didn't have much more challenges. And psychiatry seemed to me, intellectually, something interesting and stimulating. (E9, from Occupational Medicine to Psychiatry).

Personal reasons, such as maternity, illness in the family or in oneself, were also described by some interviewees.

It was really for personal reasons and if those were resolved, I would go back to anesthesia. (E5, from Anesthesiology to Nutrology)

Suddenly, all I wanted most was to be a mother. Then I went into a tailspin; what am I going to do now? Because you can't be a real mother and a surgeon, I couldn't. (E7, from Surgery to Homeopathy)

Many interviewees stated that, even though they liked the specialty, the daily practice implied an unwanted lifestyle.

What I didn't like is the pediatrician's daily life. I think the pediatrician's quality of life is very difficult. There were times when I woke up at night thinking the nurse was calling me. (E1, from Pediatrics to Psychiatry).

I loved the procedure, I still like it today, I miss it, but I like to have my non-medical moments of being able to go out, go to the mall and have a beer without the worry of having to go back to the hospital. (E3, from Surgery to Occupational Medicine).

I discovered that I didn't like to work alone in a room with the patient, I hated it, I found it monotonous, boring, dull, despite thinking the specialty was cool. (E11, from Rheumatology to ICU)

Compensation, in general, did not seem to be a fundamental factor for leaving or looking for a new area.

In Anesthesia, I earned much, much better. But you can earn well in the office now, you can have a good quality of life, I'm not crazy about working, so I have super quiet hours. (E5, from Anesthesiology to Nutrology).

Some respondents already showed some interest in the second area of choice during graduation; others had not even considered it during the course. Compensation, prejudice or lack of knowledge of this second area were some of the reasons given for not choosing at first.

In reality, I didn't take this class in college. It was an approximation and the perception of a beauty in this area, in addition to being very useful. (E16, from Gynecology to Psychiatry)

In fact, before going to medicine I wanted to be a psychiatrist. What dissuaded me was that I didn't have a good experience at boarding school." (E1, from Pediatrics to Psychiatry)

The transition and the after

Some of the interviewees mentioned difficulties in the transition phase, such as the need to take shifts. Even so, they managed to support themselves financially during that time and there were no mentions of unemployment or difficulties in entering the new field of work. On the other hand, many stated they had experienced strong social disapproval, which for some was the major stress in the transition.

In fact, people even said I was crazy because I had a very good professional position as an occupational physician. It meant giving up to start from scratch. (E9, from Occupational Medicine to Psychiatry).

I was pretty well established already, so people thought I had some mental problem. Even the colleague I left my patients to thought I wasn't

okay. I started therapy at that time, but it was more because of other's discomfort than for myself. (E10, from Pulmonology to Radiology).

Many of the interviewees, who perceive themselves as better doctors today, say they feel emotionally relieved and satisfied after the change. All are employed and without financial difficulties in the new work area. Only one doctor still mentions concerns, pointing to the possibility of making new changes.

For me it was a relief. I said "my God, thank you so much for this happening, for having gone through the residency for psychiatry, for having identified more with the team, with the themes, with the discussions". It was like they had taken about 10 kg of weight off my back. (E1, from Pediatrics to Psychiatry)

It's fantastic, I feel even more complete as a doctor in homeopathy than I did before in surgery, because I started to forget some things about the clinic. (E7, from Surgery to Homeopathy)

I am very happy, I always tell my residents "I am very happy as an anesthesiologist, and I am a better anesthesiologist because I was a pediatrician". (E2, from Pediatrics to Anesthesiology)

Some interviewees, even claiming happiness after the change, mention recognizing that, if they want, they can return to the practice of first choice.

Anyway, I don't miss anything, but I know I can still, if I want, participate in surgery. So I don't miss a thing, I'm very calm. (E7, from Surgery to Homeopathy)

Discussion

This study sought to understand the process of re-choosing the specialty, with physicians who opted for changes in their original areas of work. Little is known about these route changes within the medical career and, as a starting point, we sought to identify

whether there was, at the beginning of the subjects' professional histories, something special or different regarding the reason for being a physician.

In general, the reports express motivations for the medical career linked to conscious and classical factors. It is interesting to point out that all subjects alluded to their place within the family of origin, either as those who innovated or as those who continued a medical family tradition. In medicine, generational capital is a frequent theme in studies on vocation (Milan, 2005). Based on reports from renowned physicians, a Brazilian study deepened this issue by identifying the professional choice for medicine as a result of unconscious family strategies for the rise and maintenance of social prestige (Fiore; Yazigi, 2005). At the end of graduation, at the time of choosing the first specialty, the subjects pointed out the influence of a series of factors, highlighting the importance of undergraduate experiences, both in the course and its disciplines and in the professors, with regard to the stimulation and recognition of interests and skills for certain types of practice.

Personal and personality characteristics, as well as the type of patient and practice were mentioned by almost all study participants when choosing the first specialty, showing little reflection at that time on external, social or work context factors. Therefore, remuneration and the labor market had little influence at that time.

Issues related to practice and the world of work appeared, on the other hand, in a significant way to justify the motivations for re-selecting a specialty. Respondents found the real demands of first choice only when they experienced it in their professional settings, in medical residency or in their first jobs. Upon entering the world of work itself, doctors seemed to have little idea about employability, financial return and hours spent in the activity.

This aspect may indicate that medical training in our country, at the undergraduate stage, precariously addresses issues such as professional and career development, giving more value to the content aspects of different areas. It is possible that, during undergraduation, there is more talk about pathologies and their treatments to the detriment of approaching the real meaning of the practice of medicine in its different fields. The daily routine

of different practices, which in this study proved to be fundamental in the interviewees' process of change, was possibly not an object of investment throughout their training.

Another aspect to consider is that the interviewed group ended up being mostly women. As in many countries, there was a process of feminization of the profession in this environment, demonstrated in medical demography studies (Scheffer; Cassenote; Biancarelli, 2013). It was possible to notice, in some reports, specific gender issues, mainly related to maternity, the overload imposed by a second working day and the difficulty in entering specialties traditionally regarded as male. The gender variable has been increasingly addressed in the specialty choice literature and these results reinforce other studies that show how the specialty impacts on women's quality of life (Van Togerem-Alers et al., 2011; Alers et al., 2014).

It was found that few people switched their specialty due to change or expansion of interest. Most of the group reports having entered a process of psychic wear with the first chosen area with little time of practice. With the decision to change specialty, the interviewees thus found a possibility to adjust to the discomfort experienced in the first choice in face of aspects such as overload, work organization, hierarchy in relationships, stress with the daily practice, but also and especially, with the resulting lifestyle.

In the studied group, there are no collective solutions to the suffering within work. The reports are based on subjective discomfort, personal displeasure and the search for individual solutions. For Dejours (1992), when the worker takes a certain attitude in the professional context, this is due to subjective suffering and defensive strategies to this suffering, which seems to have occurred in this group that switched specialties.

Adaptive strategies were used when considering financial and new training issues. Some relied on family or marital financial support, the majority getting their maintenance through shifts and, thus, they specialized again with relative ease. According to the narratives, the greatest discomfort experienced by the subjects during the change process was related to social disapproval. In general,

doctors felt little understood and sometimes even attacked and perceived as failures. Even though they are re-employed and walking professionally, some doctors mention embarrassment when they need to talk about change with their peers.

Some authors reflect on the change of specialty as something with a negative meaning. Mello Filho (2006), for example, understands that the choice of specialty is an important aspect of medical identity and when it does not occur in a harmonious way, it can lead to failure, traumas in their careers and even abandonment of the profession. Vaz Arruda (1999) also argues that the success of the young person in their career and adjustment in the future depend on the initially well-made choice. If the choice was inadequate, adjustment will be more difficult and almost always achieved only through changes in area or specialty.

In this study, the subjects, unlike this traditional perspective, did not signify the change as a failure in their trajectories. The reports, in their entirety, showed that the change in specialty was felt as positive, especially when considering their new style and quality of life. This reinforces the weight of these factors in professional choices, as shown in the current literature on the subject. Zaher (1999) asked 293 doctors what changes they would like to make in their lives. Of this group, few would like to change their specialty. However, more than a third would like to take more care of themselves, devote themselves to leisure and social life.

It seems that, in the studied group, more than a new vocational construction, the search is for a more pleasurable practice that promotes greater well-being. In other words, there were more lifestyle changes than profound changes in professional identity. In addition to a vocational error, the impression is that physicians were looking for a more comfortable practice, without suffering the inconveniences felt in the field of the first specialty.

It is important, then, to understand the meaning of medical professionals favoring lifestyle, free time and quality of life to the detriment of their career. Different authors have been poring over this issue, seeking to understand it more deeply.

According to Nogueira (2007), the notion of lifestyle is in evidence in current medicine. For this

author, the birth of the idea of lifestyle, as well as the notion of quality of life, refers to individualism, designating the distinctive way in which social groups or groups are guided by their own values and tastes. The expression has been used on a large scale in medical practices and, generally, it is linked to the ideology of contemporary consumer culture, revealing the focus on individuality, self-expression and individual freedom. Therefore, being social bearers of this proposal, it is natural for physicians to apply this to their specialty and their practices, even though the social imaginary of medical work involves abnegation, altruism and dedication.

Costa (2005) points out that, nowadays, elements such as public engagement, investment in collective causes, the search for ideals and interest in the other are replaced by consumerism, cult of the body and narcissism. The term quality of life, for this author, carries with it the importance of acquiring habits that guarantee beauty, health and the ideal body shape. According to him, quality of life would be related to an excessive focus on the scientificity of the best body, well-being and the most successful practices.

According to Berenguer (2010), today's physician easily adheres to the culture of aesthetics, consumption and the primacy of having. Sick beings are excluded from this category of values and end up being depreciated. The priesthood of the profession, in this way, comes to be perceived by many as ridiculous, meaningless, useless, or absurd. Also according to this author, physicians today constantly lose the feeling of gratification for their task. The medical specialization process fragments the patient into organs and viscera and ends up framing practices as technical and distanced, worsening even more the feeling of lack of completeness.

On the other hand, the reports post-change indicated that, despite the difficulties in dealing with some type of criticism from people in their environment, the interviewees, in their entirety, were quite satisfied with the change, even expressing that they began to feel better as doctors. In many cases, it was possible to integrate the areas and expand their current practices based on the knowledge and experiences of the previous specialty. Difficulties

in relocation to work or financial hardships were not mentioned. The change was worth it, the group said. From this perspective, the trajectory, although it implies some sacrifices and is poorly understood, was possible.

Birman (2010) argues that contemporaneity is marked by the mandate to be happy. Satisfaction, individualism, perfectibility, narcissism, self-esteem and quality of life are the watchwords and paths to fulfill and achieve the so desired happiness. Physicians in this study, inserted in contemporary times, seem to have sought greater personal and professional satisfaction. This is not about condemning them for that, but about problematizing the issue within a larger context, beyond the singularities of their stories.

As a strategy to deal with dissatisfaction, weariness or disinterest, the change in specialty seems to have been positive. On the other hand, it may be important to reflect on whether there is a risk of a void of meaning for oneself and for medical practices as a whole. Couldn't these same doctors get frustrated again and wish for a new exchange and it turns out to be endless? One of the interviewees even expressed that she is waiting for a new change.

A future longitudinal study, following the repercussions of changing specialties over time, may be interesting in this regard. In the field of training, pedagogical actions expanding the student's contact with the practice of the profession, in addition to the technical characteristics of specialties, can also contribute to more grounded and critical choice processes.

Final considerations

Seeking more quality and improving the lifestyle, avoiding burnout, getting free time or developing other intellectual interests stand out as reasons for changing one's medical specialty. There are no indications that the group, in general, is focused on redressing a vocational issue.

Re-choosing the specialty is more like the desire to practice a more interesting, more comfortable or less stressful practice. If, on the one hand, it is used as a strategy to deal with the frustration and weariness of work, on the other hand, it is worth

considering the risks of a possible emptiness resulting from a certain detachment from practices.

In this sense, the physician does not seem to be detached from the larger social context. As in other professions, this professional is also inserted in an era marked by fluidity and discontent. Choices and changes will almost always reflect the gains and risks that the possibility of moving professionally more easily brings with it.

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Authors' contributions

Gosling was responsible for designing the research, collecting and interpreting data. Bellodi guided the design and execution of the research, as well as the interpretation of the results. Both prepared the manuscript and are responsible for its final version.

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