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Editorial

Beyond teaching toward a more human view of medical education

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The learner beyond the classroom

Medical education is often discussed through curricula, teaching methods, assessment, and technology. But learning is also shaped by the people who learn and teach, and by the settings in which education takes place. Students may enter the classroom with stress, uncertainty, family expectations, or financial concerns. Educators may face limited resources, changing demands, and crises that affect their work. The contributions in this issue of the Journal of Medical Education Development explore different aspects of this wider picture.

The experience of being a medical student does not end when a lecture begins. A study from Afghanistan found that 82.5% of participating male medical students reported moderate-to-high perceived stress during the examination period [1]. Academic workload, family expectations, financial difficulties, lack of academic mentorship, and difficulty managing several examinations were associated with higher stress. These findings draw attention to pressures that may remain outside the usual discussion of curriculum and teaching. The study was conducted at one university and included male students during an examination period, so its findings should be read within that setting.

Another study looks at a different part of student experience. It examined insight, self-reflection, self-compassion, and social anxiety among medical sciences students [2]. Self-compassion had a mediating role in the proposed model. This finding raises an interesting educational issue. Students in health professions are expected to speak, perform, receive feedback, and work with others. These activities can be difficult for students who are highly concerned about how they are seen by others.

Academic procrastination is also examined from a psychological point of view [3]. The narrative review uses the ideas of Acceptance and Commitment Therapy and links procrastination with psychological inflexibility, experiential avoidance, and cognitive fusion. It also considers values, committed action, present-moment awareness, and mindfulness. This view moves the discussion beyond simple time management. Sometimes the problem is not that a student does not know what to do. The task itself may bring discomfort, and the student may try to avoid that feeling.

Learning depends on more than teaching methods

The learning environment is another theme running through this issue. The qualitative study from Marrakech examined peer learning among undergraduate nursing students and educators [4]. The researchers found influences at several levels. Student motivation and previous experience mattered. So did educator preparation and the way

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groups were formed and supported. The physical and social environment also played a role. Limited resources, crowded classrooms, language barriers, workload, assessment schedules, and tensions among students could all make peer learning more difficult.

This is a useful reminder that a teaching method does not work in isolation. Asking students to learn from one another is one thing. Creating the conditions for that learning is another.

A similar idea appears in the study of the SNAPPS model among dental students [5]. After the learner-centered intervention, scores for flexibility in thinking, structure of knowledge in memory, and overall diagnostic thinking increased. SNAPPS asks learners to take an active part in presenting and discussing clinical cases. Its value, therefore, is not simply in adding another teaching method. It gives learners a larger role in the thinking that surrounds a clinical problem.

Gamification is examined in obstetrics and gynecology residency education [6]. Residents reported higher engagement and satisfaction during gamified sessions than during traditional lectures. The results are interesting, but the study also has limits. The intervention order was fixed and the topics of the sessions were not necessarily the same. Engagement and satisfaction are useful outcomes, but they do not by themselves show better clinical performance or patient care.

The study of flipped in-service training provides another example of the need to look closely at how learning is explained [7]. Achievement motivation and goal orientation were associated with perceived learning, while the only supported indirect association was through goal orientation. The authors also make a clear methodological point: because the study was cross-sectional, the observed relationships cannot be taken as evidence of causal effects. That distinction is easy to lose when educational research uses complex statistical models.

Technology and the changing educational landscape

Technology is increasingly part of health professions education. One contribution in this issue examines AI and health communication through the first cycle of a Design-Based Research study [8]. The authors reviewed recent work on patient-centered communication and brought together ideas about empathy, cultural sensitivity, simulation, virtual learning, and artificial intelligence. They then proposed a conceptual framework for the next stage of the work.

The planned intervention uses gamified scenarios and AI-enriched situations, including difficult communication settings such as medical errors. The interesting point here is not simply the presence of AI. Technology may be useful when it gives students a safe place to practice conversations that are difficult to reproduce in the classroom. Yet the proposed approach remains at the design stage. Its educational effects will need to be examined in later work.

The context in which medical education takes place

Education also reflects the society in which it operates. The commentary on social determinants of health in the Iranian undergraduate medical curriculum argues for a broader place for social factors in medical education [9]. The authors propose horizontal and vertical integration of these topics, faculty development, changes in assessment, and institutional action. Their central argument is that physicians need more than biomedical knowledge if they are expected to recognize the social conditions that shape health.

This is a proposal for educational change rather than an intervention study. Its value lies in opening a discussion about what undergraduate medical education should prepare future physicians to see and respond to.

Supporting those who sustain education

The final contribution shifts the focus from students to medical educators themselves. A narrative synthesis of 60 studies was used to develop a conceptual framework for resilience among medical educators during crises [10]. Twelve attributes were grouped into four broader concepts: Meta-attitude, Metacapability, Self-determination, and Higher-order thinking.

The framework includes qualities such as tolerance, autonomy, critical thinking, caring, creative thinking, and self-governance. It offers a way to think about what educators may need when normal educational routines are disrupted. At the same time, it is a

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conceptual framework based on narrative synthesis. Further empirical work is needed before its practical use can be fully judged.

Looking beyond individual methods

The contributions in this issue cover very different topics. Yet they share a common idea. Learning does not depend on a teaching method alone.

A student's stress may be linked to workload and the way assessment is organized. Peer learning depends partly on the space, time, and support available to students. Clinical reasoning requires active thinking rather than passive reception of information. Technology may open new ways of practicing communication, but its value depends on what learners actually do with it. Social conditions matter when medical education is expected to prepare physicians for real communities. Educators, too, need support if they are expected to teach and adapt during difficult times.

Medical education is therefore more than the transfer of knowledge. It is a human activity that takes place within classrooms, hospitals, institutions, families, and societies. The papers in this issue approach that reality from different directions. Reading them together reminds us that better education may depend not only on choosing a good teaching method, but also on creating the conditions in which learners and educators can use that method well.

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