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EDITORIAL

*Imran Jawaid**
Editor-in-Chief, Journal of Medical Education Research
Clinical Assessment Lead and Associate Professor of Professional Practice
Faculty of Medicine and Heath Sciences,
The University of Buckingham, United Kingdom

Welcome to the fifth edition of the *Journal of Medical Education Research*, an exciting collection that captures the vibrancy and complexity of contemporary medical education.

In 2025, the medical education landscape can sometimes feel like a dystopian novel; dashboards, checklists, NSS scores and MLA outcomes crowd the horizon, while AI quietly grades OSCEs or delivers lectures. Yet for all our digital sophistication, no algorithm has successfully captured the true complexity of clinical practice, like the moment a doctor discovers that, despite completing seventeen mandatory e-learning modules, none of them covered how to make the printer work. Clearly, some competencies lie beyond the reach of modern pedagogy (although one hopes the next curriculum update might finally include *'Introduction to Hospital Printer Behaviour: A Survival Guide'*).

Research in medical education matters — it illuminates not only what we teach, but how knowledge, skills and values are translated into practice. Competent, reflective and ethically grounded physicians emerge not from metrics alone, but through thoughtful implementation, mentorship and lived experience.

Burnout among medical students remains all too real. Gendered pressures, heavy workloads, and patchy support erode wellbeing, with consequences for learners and institutions alike. Recent studies in this edition confirm that female students experience higher stress in emotional and academic domains, while male students favour problem-focused coping strategies. Removing gender-specific biases, enhancing self-efficacy, expanding extracurricular opportunities and embedding mindfulness are not luxuries; they are essentials. Shakespeare reminds us, "When sorrows come, they come not single spies but in battalions" (*Hamlet*) and institutions must confront these battalions of stressors with mentorship, structured guidance and practical support.

Transition into practice represents another critical hurdle. Surveys of PGY1 doctors in New Zealand reveal confidence in histories and communication, yet many report feeling underprepared to manage deteriorating patients, participate in resuscitation, or prescribe safely. This is hardly

*Corresponding author: e-mail: imran.jawaid@buckingham.ac.uk

surprising; no simulation quite prepares you for the moment a senior doctor says "you're leading this one," with the same casual tone one might use when offering someone a cup of tea. Undergraduate curricula must mirror clinical realities; knowledge alone is insufficient. Implementation of research into supervision and structured mentorship, as exemplified by postgraduate doctors acting as clinical supervisors for foundation trainees, demonstrates how educational evidence can be translated into programmes that cultivate competence, confidence and resilience.

Simulation and emerging technologies provide complementary tools, enhancing knowledge, attitudes and, in some cases, skills. Extended Reality and structured simulation allow learners to rehearse clinical scenarios safely, supporting the translation of theoretical knowledge into clinical practice. Yet education is moral work. As Kant might remind us, we do not merely transfer knowledge; we shape clinicians capable of judgment, empathy and ethical reasoning. Communication, compassion, and moral discernment cannot be coded into an algorithm.

Inclusion and cultural competence remain ongoing challenges. While many medical curricula have incorporated teaching on race and ethnicity, research suggests that representation remains uneven – certain identity dimensions including sexual orientation and gender identity (LGBTQ+), disability and intersectional identities are less consistently covered. As a result, some students and patient groups continue to feel under-represented and experience gaps in both teaching content and clinical education. To paraphrase George Orwell, the notion that 'all groups are equal, but some groups are more equal than others' can regrettably still ring true in medical education today.

Students are not passive vessels waiting for us to pour wisdom into them. Their ability to choose, adapt and assemble their own learning ecosystems is what often makes the difference between surviving and actually thriving. Investigations into medical student resource use show that active engagement with digital platforms, physical notes and collaborative study correlates with perceived learning effectiveness. Programmes fostering urban health leadership and co-designed curricular innovation highlight how research, when implemented thoughtfully, shapes not only knowledge but professional identity, social responsibility and lifelong learning. Medicine and medical education are lifelong pursuits. Students must take responsibility for their own learning and educators remain perpetual students of pedagogy, whilst ensuring patients remain at the heart of everything we do.

Amid the continuous pressures, small miracles continue to occur – students learn things, patients generally improve thanks to our care and education cheerfully trundles along as if blissfully unaware of the surrounding chaos. We have a remarkable talent for making everything more complicated than it needs to be, yet the system still manages to function, powered not just by evidence, but by optimism, caffeine, and the collective willpower of those who suspect

that “normal service” may be more a myth than reality. It is not perfection; it is medicine, which is infinitely more entertaining.

I will leave you with this little limerick:

There once was a student so bright
Who studied long into the night
But textbooks alone
Their skills could not hone
To cure and to care with insight