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Liter to Editor (Pages: 1435-1438)

AMEE 2026 and the Future Of Medical Education: Turning Compelling Principles into Measurable Institutional Change

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Abstract

AMEE 2026 positions medical education around a safer, more equitable, and more human future. This letter argues that these principles will have lasting value only when translated into measurable institutional action. Medical schools should treat psychological safety, equity, humanism, and responsible educational innovation as core outcomes of curriculum design, assessment, faculty development, and governance.

Safety must include protection from mistreatment and humiliation. Equity must extend from admissions through assessment, clinical placements, progression, and career advancement. Humanism should be explicitly taught and credibly assessed, while artificial intelligence and digital tools must be evaluated for accessibility, validity, ethics, and their benefits for underserved learners. Institutions should publish measurable commitments, monitor progress, and engage learners, educators, patients, and communities in educational reform.

The future of medical education should be judged not by the novelty of its innovations, but by whether they improve learning conditions, professional identity, equity, and patient care.

Key Words: AMEE 2026, Artificial intelligence, Institutional change, Medical education, Patient safety.

*Please cite this article as: Sharifzoda SA. AMEE 2026 and the Future Of Medical Education: Turning Compelling Principles into Measurable Institutional Change. Med Edu Bull 2026; 7(2): 1435-38. DOI: **10.22034/meb.2026.613085.1155**

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Received date: Sep. 15, 2026; Accepted date: Nov.12, 2026

Dear Editor,

The emerging discussion surrounding AMEE 2026 provides an important opportunity to reconsider what medical education should achieve in a rapidly changing health-care environment. The conference framing—toward a safer, more equitable, and more human future—should not remain a statement of aspiration. It should become a practical agenda for curriculum design, assessment, faculty development, institutional governance, and accountability (1).

Medical education is being reshaped by artificial intelligence, widening health inequalities, changing patterns of clinical practice, increasing learner distress, and growing expectations that graduates will respond to the social determinants of health. In this context, the central question is not whether medical education should change, but whether it can change deliberately, inclusively, and in ways that improve both learning and patient care (1, 2).

Safety beyond the bedside

First, safety must be understood broadly. Patient safety remains central, but educational environments must also protect learners from humiliation, discrimination, excessive workload, neglect, and avoidable psychological harm. Learner mistreatment is a longstanding international problem that can discourage students from asking questions, reporting errors, acknowledging uncertainty, or seeking support (3).

A culture that expects learners to remain silent about mistreatment or uncertainty is incompatible with the development of reflective, ethical, and dependable clinicians. Neglect—such as exclusion from meaningful participation in clinical teams—can itself constitute mistreatment and may harm both learning and well-being, regardless of whether it is intentional (4).

Medical schools should therefore treat psychological safety as an educational and quality-improvement outcome, not merely as a well-being initiative. This requires confidential reporting routes, protection from retaliation, transparent response procedures, and monitoring of whether concerns lead to meaningful action. Faculty development should address respectful supervision, feedback without humiliation, bystander intervention, and the responsible use of authority (5).

Learners should also be taught that speaking up, escalating concerns, and acknowledging uncertainty are professional behaviours rather than signs of weakness. High psychological safety should coexist with high accountability: teams should be able to raise concerns without fear while remaining responsible for safe, ethical, and patient-centred care (5).

Equity across the pathway

Second, equity requires more than widening access. It requires examining how admissions, curriculum content, assessment practices, clinical placement systems, remediation, progression decisions, and academic career pathways may advantage some learners over others. A student may be admitted through an inclusive process yet still encounter inaccessible materials, unrepresentative clinical cases, inflexible attendance requirements, biased assessment, or clinical environments that fail to accommodate disability and difference.

Recent discussion of disability-conscious admissions illustrates why medical education must move beyond individual accommodation toward the design of learning environments that anticipate human diversity. Fairness does not necessarily mean treating every learner identically; it may require removing unnecessary barriers and distinguishing essential professional competencies from traditional but poorly justified methods of demonstrating them (6).

This principle should extend to socioeconomic background, race, gender, language, culture, geography, disability, and prior educational opportunity. Institutions should analyse assessment and progression data by relevant demographic groups, investigate unexplained disparities, and involve affected learners in designing practical solutions. Equity-driven approaches should also include community engagement, interprofessional collaboration, advocacy, and attention to the structural determinants of health (2).

Humanism as an outcome

Third, humanism should be treated as an educational outcome rather than an optional professional virtue. Competence includes communication, compassion, moral reasoning, collaboration, humility, and the ability to recognise patients as people whose priorities may differ from institutional expectations. These capabilities should be taught explicitly, modelled by faculty, assessed credibly, and protected throughout clinical training.

When humanistic values receive less curricular and assessment attention than biomedical knowledge or procedural skill, the hidden curriculum may undermine the values that formal curricula claim to promote. Students may learn that speed, hierarchy, emotional detachment, and performance are rewarded more than listening, empathy, and relationship-centred care.

A humanistic curriculum should connect professional identity with real clinical decisions. Learners need structured opportunities to explore moral distress, disability, racism, stigma, poverty, cultural difference, end-of-life care, confidentiality, conflict, and the limits of medical authority. These issues should be integrated into case discussions, simulation, reflective practice, clinical supervision, and workplace-based assessment, rather than confined to isolated lectures.

Faculty role modelling is itself a form of teaching. Learners notice how patients, families, colleagues, and junior staff are treated. Therefore, institutions must support educators with time, recognition, and training to become effective teachers, mentors, assessors, and inclusive role models.

Innovation with purpose

Finally, innovation should be judged by educational and clinical value, not by novelty alone. Digital tools, artificial intelligence, simulation, learning analytics, and virtual patients may improve learning, but only when they are accessible, valid, ethically governed, and responsive to patient and learner needs. Technology is not automatically equitable or educationally sound; poorly designed tools can reproduce bias, widen the digital divide, compromise privacy, increase surveillance, or encourage superficial performance (1, 7).

For artificial intelligence in particular, students and educators need more than technical instruction. They need artificial-intelligence literacy: the ability to check accuracy, recognise fabricated or biased outputs, protect confidential information, disclose appropriate use, and retain human responsibility for clinical decisions (1, 7).

Assessment should evolve accordingly. If learners are expected to work in partnership with intelligent systems, examinations should test judgement, verification, explanation, communication, collaboration, and safe decision-making—not only unaided recall of information. AMEE Guide No. 178 similarly emphasises that artificial intelligence in assessment must be grounded in educational theory, address ethical challenges, and consider faculty development and appropriate acknowledgement of artificial-intelligence use (7).

Every innovation should therefore be evaluated against a simple question: does it improve learning, care, equity, or safety—and for whom? Innovations that benefit only well-resourced learners, or that shift educational burden onto students and faculty without clear benefit, should not be considered progress.

From principles to accountability

AMEE 2026 can make a lasting contribution by encouraging institutions to publish measurable commitments rather than broad declarations. Useful indicators might include reductions in learner mistreatment, improved psychological-safety scores, timely resolution of reported concerns, narrower assessment and progression gaps, accessibility of learning resources, inclusive curriculum representation, participation in faculty development, and evidence that innovations benefit underserved learners (1, 5).

Quantitative indicators should be complemented by qualitative accounts from learners, educators, patients, and communities. Educational leaders should also ensure that reform is not dependent on a

small number of motivated individuals; it requires policies, resources, promotion criteria, and governance structures that make inclusive and humane education sustainable.

CONCLUSION

The central lesson is clear: safer, more equitable, and more human medical education is not an additional theme competing with academic excellence. It is a condition of academic and clinical excellence. Learners who can ask questions without fear, patients who are represented and respected in the curriculum, and educators who are supported to teach inclusively are more likely to contribute to trustworthy health care. The success of AMEE 2026 should therefore be judged not by the number of new ideas discussed, but by the extent to which those ideas produce durable improvements in educational practice, learner well-being, equity, and patient outcomes.

CONFLICT OF INTEREST: None.

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