Medical Student: Ornament or Decision Maker?

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We live in a world defined by the paradox of immediacy, where, in the healthcare sector, constant updating has ceased to be an advantage and has become a requirement for survival. In this scenario, 21st-century global health is no longer sustainable if it relies solely on the traditional "healer" limited to diagnosis; on the contrary, the current system demands a new lineage of informed, socially responsible professionals capable of influencing decision-making and public policy. In light of this situation, a pressing question arises: how can we, as medical students, adapt our own training to meet these contemporary demands? The answer lies in a concept that is a cornerstone of systemic transformation, although it is often relegated to the theoretical realm: advocacy.

The catalyst: when the curriculum is deficient

Just a few days ago, as part of the close contact we maintain with other local association officers, we received a message that encapsulates the urgency of this debate. A colleague expressed deep concern about his faculty: its curriculum had undergone a series of structural changes, but these were implemented without the consensus or consent of the student body.

This incident is not an isolated case, but rather a symptom of a systemic disconnect. When curriculum design ignores the student's voice, there is a risk of training professionals for a world that no longer exists. The curriculum should not be a rigid document, but one that responds to current demographic needs and integrates new technologies not as an accessory, but as a fundamental tool of modern medical practice.

Ignoring students' voices in educational development is not merely an administrative oversight, but a sentence to professional passivity. By relegating the student to the background, their sense of agency and responsibility is fractured, turning future leaders into mere executors of processes they neither understand nor share. The real consequence is the creation of an insurmountable gap between the classroom and clinical reality: a generation of physicians who are technically competent but politically inert and socially disconnected. Ultimately, the price of this exclusion is paid by the healthcare system as a whole, which ends up inheriting professionals without the critical capacity or the empowerment needed to defend—and transform—their patients' lives.

Defining Social Accountability (SA)

To understand why students must have a voice, we must refer to the World Health Organization's (WHO) definition.

The WHO defines the social accountability (SA) of medical schools as the obligation to direct their educational, research, and service activities toward addressing the priority needs of the community, region, and/or nation that has entrusted them with the mandate to serve [1].

These priority needs are not static. If the faculty has this obligation to society, young people and medical students should be regarded as agents of change, promoting intergenerational collaboration through sustainable participation, with feedback and accountability.

Meaningful Youth Participation (MYP)

One way students can contribute to the faculty's social responsibility is through the MYP.

It's easy to get stuck in symbolic participation without achieving meaningful participation, which is why it's essential to identify them, ensuring our voice is heard and taken into account. There are eight levels of youth participation. Figure 1

- Manipulation
- Decoration
- Assigned but informed
- Consulted and informed
- Initiated by adults, sharing decisions with young people
- Initiated and led by young people
- Initiated by young people, sharing decisions with adults

True participation involves:

- Intergenerational Collaboration: A horizontal dialog where teachers' experience is enriched by technological proficiency and students' fresh perspectives.
- Sustainable Participation: That student consultation mechanisms be institutionalized and not depend on the charisma of a leader in office.
- Accountability and Feedback: Student opinions have a traceable impact on curriculum design and resource management.

Viewing young professionals as true agents of change allows medical education to shift from a process of "information consumption" to one of "value co-creation."

Tools for action: advocacy, public speaking, and debate

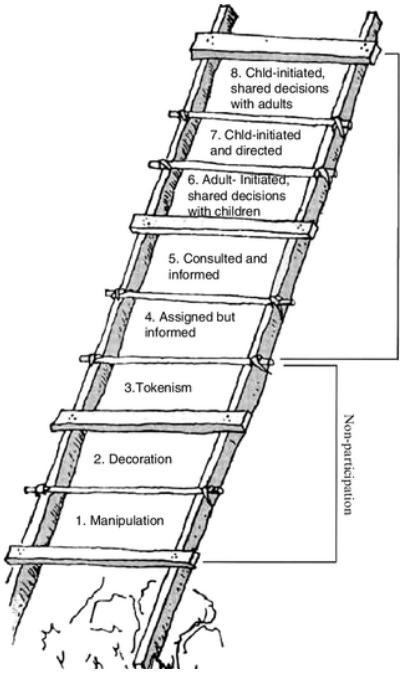
For a student to be able to influence and demand social responsibility, it is not enough to have the intention; technical tools are required. Advocacy is the set of actions aimed at influencing public policies and the allocation of resources within political, economic, and institutional systems. [3] Advocacy is the set of actions aimed at influencing public policies and the allocation of resources within political, economic, and institutional systems. [3]

In our context, we seek to implement activities in which advocacy is expressed through:
Public Speaking and Debate: Not as aesthetic ends, but as clinical and political competencies.

A student who is proficient in debate can dissect an administrative argument, identify fallacies in a curricular proposal, and propose evidence-based alternatives. Debate fosters critical thinking, enabling physicians to advocate not only for their individual patients but also for entire populations before bureaucratic systems.

Open Space Discussions (OSD) and Forums: These dialog methodologies allow individual hallway concerns to be transformed into a collective consensus. The use of new technologies makes these forums inclusive, allowing the voice of a student in a remote area to carry the same weight as that of one in the capital.

Curriculum development within Kern's six-step framework[4]: It is imperative to develop a curriculum in a bilateral, evidence-based, and socially responsible manner; this tool facilitates this inclusive process.

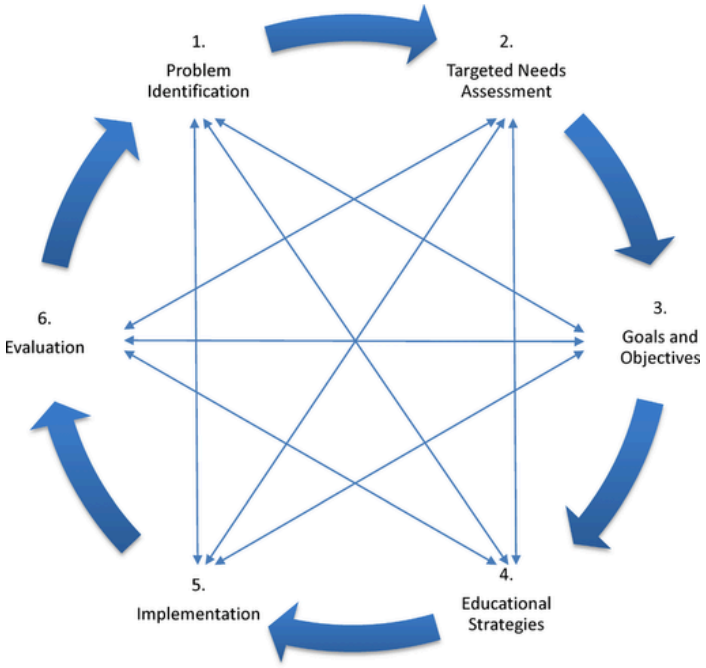


C.28.1. Ladder of levels of meaningful youth participation. Hart, Roger. (2008). Stepping back from "The ladder": Reflections on a model of participatory work with children.

The doctor as an intermediary in a digital world

The globalized world demands that physicians be advocates. In an environment where misinformation spreads faster than evidence, health professionals must occupy decision-making spaces. If, during our training, we are not allowed to participate in designing our own curriculum or in the governance of our faculty, we will hardly have the skills to lead complex health systems in the future.

Medical education must integrate health policy literacy with the same rigor as clinical training. Only in this way can we close the gap between what the university teaches and what society needs.



C.28.2. Kern's 6 steps for Curriculum Development. Wagner, M. & Fischer, Martin & Scaglione, Mariano & Linsenmaier, Ulrich & Schueller, G. & Berger, Ferco & Dick, Elizabeth & Basilico, Raffaella & Stajgis, M. & Calli, C. & Vaidya, S. & Wirth, Stefan. (2017). Subspecialization in Emergency Radiology: Proposal for a harmonized European curriculum. GMS Journal for Medical Education. 34. 10.3205/zma001138.

Conclusion

Global health cannot be sustained solely by "healers" with a technical vision. The contemporary world needs doctors who understand that their work begins long before the consultation and ends long after the prescription. It begins with advocating for quality education and ends with political advocacy to ensure equitable health systems.

C.28.3. Board of Directors of the LEMEP Local Committee at the National Forum "Human Rights of Medical Students, Legislative Proposals for the Vindication of their Rights", July 2025 - Chamber of Deputies