Students' social media fixation – an escape from force-fed medical education?

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Abstract

As a senior medical educator, the social media fixation of the current generation of medical students and the suspect quality of medical education concern me. Through my octogenarian eyes, I see a major difference in daily social interaction. As we pass to and from class, a greeting or even eye contact is now a rarity. Students must have their phones in-hand and at the ready for a text, a meme, an update on the precise whereabouts and activities of a friend. In fairness, the phone is a part of their limited escape from a medical education which is being force-fed to them. As a student, the volume of information in the study of medicine was overwhelming to me. Now, in the era of molecular genetics, monoclonal antibodies, stem cells, sophisticated imaging, robotics, and artificial intelligence, it is impossible to do anything other than to binge on a steady staccato of facts. Experts are not necessarily the best teachers. A small committee of 5-10 members could hash out and carefully select a shorter list of key topics any physician should understand and be certain that they are taught well. Medical educators might be hired to take the bulk of teaching responsibilities for medical students in a given module. Resolution of cellphone attachment may result in a physician focused on introspective questioning and discussion of how we choose to become the best version of ourselves and what the impact of our doctoring might be on our families and colleagues when it's over.

Keywords: medical education, philosophy of learning, lecturer quality, content of learning

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I freely confess that I am an old-school physician and being a doctor is all I've ever wanted to do with my life, except perhaps in grade school and little league when professional baseball had some appeal. I was eventually cured of that notion when I reluctantly accepted the fact that I was mediocre at best on the baseball team at St. Patrick High School. Today, the social media fixation of the current generation of medical students and the suspect quality of medical education concern me.

Pre-med at Notre Dame was very challenging for a student like me who had to put in many more hours than seemingly most of my classmates. My extracurricular activities were limited to being a member of the Glee Club which gave me a lifelong passion for choral music. Because trying academic periods were not uncommon, and because of my love of singing, I sometimes considered chucking it all in and auditioning for a professional chorale. However, once the self-pity subsided, I knew that medicine was my vocation and kept studying hard.

The Medical College of Virginia (now Virginia Commonwealth University) reviewed my application and most likely took a flier on me. In my freshman year as a consequence of examinations in anatomy, physiology, histology, and the biochemistry of various organ systems, I was well back in the pack of 100 rising sophomore students by the next June. I sluggishly made my way up to the middle of the class in the study of pathology and clinical medicine, and finally hit my stride on rotations taking care of sick people, and landed a solid internship at the University of Cincinnati.

Since then, love of patients, the passion and sheer joy I found for teaching clinical medicine to anyone junior to me, a fascination with fungal disease, and a quite unexpected interest in clinical research has given me a career as a medical educator in the Division of Infectious Diseases at the Medical College of Georgia at Augusta University for the better part of 50 years. I'm still at it at 82, trying to pass along clinical pearls my professors taught me to the modern medical student.

Through my octogenarian eyes, I see a major difference in daily social interaction. As we pass to and from class, a greeting or even eye contact is now a rarity. I often step to the side to avoid a collision as they are coming in my direction. Unless they have been to one of my lectures, the vast majority intend me no bodily harm; they simply

don't notice me because they are riveted on videos, messages, and images on their smartphones in literally any weather, fair or foul. Such tunnel vision is not completely their fault since practically from birth they have been entertained by the flashing and ever-changing images and sounds on some kind of a video screen.[1] They didn't realize it then, but they were only just getting started. For many of them, both parents had significant work demands. As a result, the TV became their favorite and mesmerizing babysitter at home while Mom threw together a breakfast and then afterwards dropped them off in day-care centers. Video games became even more addictive later and consumed hours waiting for a parent to get home.

When these games became three dimensional, sometimes weeks went by, interrupted only by meals, the bathroom, and school. For some of them Mom and Dad supplied a cell phone with internet access in middle school or even earlier, and nobody knows what kind of scenes captivated them then. As a rite of passage and initiation, they first flocked to Facebook, but platforms like TikTok, Instagram, and podcasts began to compete for their attention, and now have become today's dominant forms of their entertainment. The watchword is *entertainment.*

We were more fortunate in our generation. We made up our own entertainment outside digging in the dirt, playing all kinds of tag, hide-and-seek, and just being outdoors. We stayed outside until we were called in for dinner. When TV came along in the 1950s, we did look forward to the programs on the few available channels and it's difficult not to get hooked on the infinite variety of sports, comedy, and drama available to us now. There was one big difference in our upbringing—we already instinctively *knew* how to entertain ourselves.

Gen Z's medical students, by and large, *do not*. They must have their phones in-hand and at the ready for a text, a meme, an update on the precise whereabouts and activities of a friend—and not necessarily a close friend at that. They *have* to be entertained at all times. There's not a second set aside for a contemplative thought about who they are, why they exist, their future patients, their goals in life, or just a quiet walk. They must be online.

In fairness, the phone is a part of their limited escape from a medical education which is being force-fed to them. I had always thought that my studies at Notre Dame were more difficult conceptually than those at medical school. It was the volume of information in the study of medicine which was so overwhelming to me. But that was then. Now, in the era of molecular genetics, monoclonal antibodies, stem cells, sophisticated imaging, robotics, and artificial intelligence, it is impossible to do other than to binge on a steady staccato of facts. There is no time to sort the useful ones from the trivial and all will be purged as soon as the exam is over and study begins on the next body system or clinical rotation.

Where is their room for true understanding and long-term memory of the most relevant fundamentals of human anatomy, physiology, genetics, pharmacology, physical diagnosis, and patient assessment? Answer: There isn't! Our approach to medical education is broken and we and the accrediting bodies don't seem to realize it. The ultimate victims are going to be our patients.

We, the professors, assume we know what medical schools should teach, but we already have our degrees and are comfortable with our salaries and leadership positions. However, how much do we really understand about disciplines other than our own little world of expertise? Nevertheless, those of us on curriculum committees of 50-plus members continue to believe that students learn best in the lecture hall from an expert. Whether the expert knows *what* to teach is a subject which should carefully be debated in committee meetings and more importantly, *how to teach it*. Those teaching methods vary considerably and are usually designed not with the learner in mind.

Unfortunately, the easiest default position for a professor giving a lecture is to cover a subject in a state-of-the-art fashion, replete with tiny bullets of minutia impossible for students to enter into even short-term memory. They then toward the end of their lecture have to rush through the final slides and inevitably infringe on the next speaker's time. After all, this is the lecture style to which they have been accustomed since their own student days, with nary a thought about its efficacy for the learner. Their MD or PhD most certainly doesn't make it so. Furthermore, most lecturers are not trained communicators, making it fortuitous if students benefit from even being there. Is it any wonder that lecture halls are virtually empty in most medical schools—especially when presentations are recorded and PowerPoint handouts are sent to the students in advance? Most of our lecturers are completely unaware that, behind the scenes, they suffer the indignity of being fast-forwarded, and likely some with utter disdain and derision. A somewhat amusing irony is that many professors are incensed that only a few "gunners" came to hear them pontificate. Meanwhile, most of the students are in their apartments or dorms just getting up, checking messages on Instagram, or out for a run. A few never intended that any lecture should interrupt their daily routine on an elliptical or bench-pressing 180 pounds at the gym. Sometime

later, they will dutifully binge on the contents of that overly complex handout which contains a plethora of facts of no use to any patient they will ever encounter. Once a passing grade is entered into their transcripts, it is soon to become a part of the detritus at the bottom of their shredder when the next body-system module begins.

For example, if *Endocrine and Metabolism* is next, a workable understanding of concepts like the pathogenesis of diabetic ketoacidosis would most likely be buried amidst the bullets about retinopathy, neuropathy, glycated hemoglobin, and other complications of diabetes. Why not have a ***small*** committee of 5–10 members[2] hash out and carefully select a shorter list of key topics any physician should understand and be certain that they are taught well? For that, the professor whose main focus of research is glucagon-like peptide-1 agonists may or may not be the best choice for a lecture. However, the clinical endocrinologist or basic scientist with bona fide teaching abilities might be a wiser choice to lecture on *all* major subjects. With that in mind, similar kinds of medical educators might be hired in other specialties giving them the bulk of teaching responsibilities for medical students in a given module. Until the module concludes, that professor should have no other responsibilities. Keeping aware of, but not consumed by, students' future certifying exams, their only assignment should be to prepare innovative lectures on subjects which will reinforce the development of a competent physician. Another skilled communicator can be assigned to attend at least one lecture by each presenter to offer constructive criticism on lecture technique in every module. Progressive quality improvement in teaching ought to follow from such an approach.

For the development of clinical skills, standardized patients have now become the norm for teaching physical diagnosis to first- and second-year students, and most physician-preceptors are reasonably adept at demonstrating inspection, palpation, percussion, and auscultation. Whether students remember how to apply them to a sick person on the wards is likely to depend on the enthusiasm and skill of supervising residents and attending physicians for bedside teaching, and the formal incorporation of it into the curriculum for clinical rotations.[3] Unfortunately, the perpetual beckoning of the electronic medical record for billable daily notes may supersede teaching students how to properly palpate for splenomegaly.

It is time for a manageable committee of clinicians and educators with expertise and interest in curriculum development to meet regularly and challenge the status quo improving those aspects of medical school which work well and abandoning those which should be dissected away. Medical school will still signify an arduous and challenging choice of profession, but the overarching goals of those who teach should be the compassionate and expert care of the sick by competent physicians. Positive achievement outcomes likely will be reflected in the yearly class scores on certifying examinations, because students will have developed more long-term memory of the most essential concepts of pathogenesis, diagnosis, and treatment. Institutional assessment by those responsible for ongoing accreditation of the medical school should be awaited with less apprehension and trepidation, and with the confidence that their medical school graduates will be among the best physicians trained anywhere.

The resolution of Gen Z's pathologic attachment to their cellphones may result in a physician of a different sort, perhaps one whose focus is on introspective questioning and discussion of how we choose to become the best version of ourselves, and indeed what the impact of our doctoring might be on our families and colleagues when it's over. Meanwhile, for personal safety while walking, stay alert for medical students aimed in your direction while focused on their phones.

References

1. Haigt, J. *The Anxious Generation.* 2024; Penguin Random House.

2. Ekpenyong A, Padmore J, Hauer K. The purpose, structure, and process of clinical competency committees: Guidance for members and program directors. *Journal of Graduate Medical Education* 2021;13: 45–50.

3. Garibaldi B, Russell S. Strategies to reinvigorate the bedside clinical encounter. *New England Journal of Medicine* 2025;393: 2142–50.