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The echo of “no”: how the word that denies silences the mind of the innovative future doctor.

El eco del “no”: cómo la palabra que niega, silencia la mente del futuro médico innovador.

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Summary.

The language used in clinical teaching plays a central role in how students and residents construct their learning, their motivation, and their relationship with error. Based on training experiences in Emergency Medicine, this study reflects on the repeated use of negation expressed as a categorical "no" as a common corrective mechanism in clinical teaching settings, and on how this form of interaction can affect the learner's psychological safety, willingness to participate, and cognitive processes. Drawing on insights from medical education, the neuroscience of learning, and emotional intelligence, the study analyzes the emotional, ethical, and pedagogical implications of this type of language, as well as the cultural and hierarchical factors that contribute to its persistence. Finally, it proposes the need to move toward more guiding and reflective forms of feedback, capable of maintaining academic rigor without resorting to fear, and promoting safer learning environments that are more conducive to critical thinking and innovation.

Keywords: Medical Education, Language, Psychological Safety, Internship and Residency, Learning.

Resumen.

El lenguaje utilizado en la docencia clínica cumple un papel central en la forma en que los estudiantes y residentes construyen su aprendizaje, su motivación y su relación con el error. Desde la experiencia formativa en Medicina de Urgencias, se reflexiona sobre el uso reiterado de la negación expresada en un “no” categórico como mecanismo correctivo habitual en entornos clínico-docentes, y sobre cómo esta forma de interacción puede afectar la seguridad psicológica, la disposición a participar y los procesos cognitivos del aprendiz. A partir de aportes de la educación médica, la neurociencia del aprendizaje y la inteligencia emocional, se analizan las implicaciones emocionales, éticas y pedagógicas de este tipo de lenguaje, así como los factores culturales y jerárquicos que favorecen su persistencia. Finalmente, se plantea la necesidad de transitar hacia formas de retroalimentación más orientadoras y reflexivas, capaces de mantener el rigor académico sin recurrir al miedo, promoviendo entornos de aprendizaje más seguros y favorables para el pensamiento crítico y la innovación.

Palabras clave: Educación Médica, Lenguaje, Seguridad Psicológica, Internado y Residencia, Aprendizaje.

Medical training has historically been a space of high technical demand, but also a setting where hierarchical models are reproduced, in which mistakes are punished and doubts are silenced. In this context, a short and seemingly innocuous word, "no," has acquired disproportionate weight within the teacher-student interaction. Used repeatedly and without subsequent guidance, negation not only corrects but can also invalidate the learner's reasoning, inhibit their participation, and damage the pedagogical relationship.

From my experience training in Emergency Medicine, the paradox of contemporary medical education is evident. While the literature promotes psychological safety, emotional intelligence, and empathic learning, teaching practices based on denial and fear persist. This contradiction reflects an ethical shortcoming in the training of professionals who, paradoxically, will be responsible for the care of others. In this context, "no" is not just a word, but the expression of a culture that confuses rigor with humiliation.

This paper reflects on the meaning of "no" as an act of power in clinical teaching, analyzes its emotional and neurocognitive impact, examines the reasons for its persistence, and proposes alternatives aimed at more formative feedback. The premise is clear: teaching through negation does not foster critical thinking, but rather avoidance and fear. The pedagogical challenge lies in transforming the paralyzing "no" into a language that guides, questions, and motivates.

1. The “no” as an act of power and negation

Clinical training settings are spaces where knowledge and power coexist in tension. The instructor not only assesses competencies but also defines which forms of reasoning are acceptable. In this hierarchical microcosm, repeated denial can function as a symbol of authority rather than a pedagogical tool. It has been shown that in environments with high hierarchical distance and low inclusive leadership, the psychological safety of learners decreases, generating fear of participating and expressing ideas (1). In clinical practice, this translates into silence, self-censorship, and avoidance of reasoning aloud—phenomena that are particularly problematic in emergency departments, where open discussion is key to making sound decisions. The impact of this model is not only emotional. Psychological insecurity reduces the willingness to engage in collaborative learning and affects the perception of fairness in medical training (2-3). When correction is associated with humiliation, threat responses are activated that interfere with working memory and clinical reasoning (4). At that point, teaching ceases to be a cognitive process and becomes an experience of self-protection.

2. Emotional and neurocognitive impact of denial

Meaningful learning depends on the integration of emotion and cognition. Neuroscience has shown that exposure to negative stimuli activates stress networks mediated by the amygdala, diverting resources from the prefrontal cortex, a key region for critical thinking and decision-making (4). From this perspective, every “no” expressed in a tone of rejection can act as a micro-threat that disrupts the consolidation of learning. This phenomenon has also been described in motivational psychology, where repeated negative correction fosters a fixed mindset, characterized by the avoidance of error and cognitive challenges (5). In contrast, environments that validate the reasoning process, even when the answer is incorrect, promote a growth mindset and greater engagement with learning. In medical education, however, a tendency to dissociate emotion and cognition persists. The intellectualization of practice has led to the invisibility of emotion as a legitimate form of knowledge, contributing to the dehumanization of the training process (6). Paradoxically, empathetic and trusting environments are associated with greater intrinsic motivation and better knowledge retention, while negative language blocks curiosity and flexible thinking (4).

3. The persistence of the model: tradition and dogma

Despite the available evidence, teaching based on denial remains a common practice. Its roots are historical and cultural. Medicine has been built on a model of vertical knowledge transmission, where the teacher's authority is associated with control and infallibility. This phenomenon has been described as a pedagogy of dogma, which privileges obedience over critical thinking (7). Teachers tend to reproduce the models with which they were trained, perpetuating dynamics that normalize censorship and the silencing of error. In many clinical-teaching settings, verticality continues to be interpreted as synonymous with discipline, even though inclusive leadership and low power distance are associated with greater psychological safety (1). This anachronism contradicts decades of evidence linking psychological safety with better learning outcomes and a lower risk of error (8). In emergency settings, where uncertainty is inherent, silencing the learner does not strengthen clinical safety, but rather compromises it.

4. Emotional intelligence and psychological safety as training alternatives

Overcoming the pedagogy of denial does not imply lowering academic standards, but rather humanizing feedback. Emotional intelligence offers a conceptual framework that integrates self-awareness, self-regulation, and empathy—essential competencies in medical education (9). Psychological safety is defined as the perception that it is possible to ask questions, express opinions, or make mistakes without fear of reprisal (8). In the clinical training environment, this allows students to express doubts or acknowledge limitations without feeling humiliated. Evidence shows that programs incorporating feedback focused on behavior rather than the person promote participation, confidence, and knowledge retention (10). From the experience of emergency medicine, this approach is especially relevant, given the dynamic, uncertain, and collaborative nature of clinical practice. Training professionals capable of reasoning under pressure requires environments where mistakes can be analyzed without fear.

5. From judgment to guidance: transforming teaching language

Change in medical education depends not only on new methodologies but also on a conscious transformation of language. Replacing categorical "no" with guiding questions or invitations to analysis does not weaken rigor but rather strengthens it. Expressions that open dialogue preserve academic precision and reduce fear as a mediator of learning. When teaching discourse is formulated from a guiding perspective, students no longer feel constantly evaluated and begin to perceive themselves as active participants in the learning process. Self-efficacy, motivation, and creativity—essential elements for meaningful learning—are strengthened (5,9). Thus, the clinical classroom recovers its function as a space for shared thinking and knowledge construction.

Conclusions

- The word “no” has been a silent constant in medical education. Its linguistic brevity contrasts sharply with its emotional and cognitive impact. Used from a position of authority and without guidance, it can inhibit curiosity, impoverish reasoning, and transform learning into a defensive experience.

- Rethinking teaching language doesn't mean abandoning rigor, but rather recognizing that educational excellence is best achieved in environments where mistakes are analyzed and addressed. In Emergency Medicine, training professionals capable of thinking under pressure requires fewer imposed silences and more guiding dialogues. Transforming the echo of "no" into an invitation to critical thinking is an ethical responsibility of contemporary medical education.

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