Strides Dev Med Educ. 2026 July; 23(1):e1756. doi 10.22062/sdme.2026.202580.1756

Letter to editor

Military Crises and Pediatric Medical Curricula

Mahmoud Khodabandeh*

MD, Department of Pediatric Infectious Diseases, Children's Medical Center, Pediatric Center of Excellence, School of Medicine, Tehran University of Medical Sciences, Tehran, Iran

Received: 2026 May 19; Revised: 2026 July 01; Accepted: 2026 July 27; Published online: 2026 July 27

*Corresponding author: Department of Pediatric Infectious Diseases, Children's Medical Center, Pediatric Center of Excellence, School of Medicine, Tehran University of Medical Sciences, Tehran, Iran.
Email: khodabandeh@farabi.tums.ac.ir

Citation: Khodabandeh M. Military Crises and Pediatric Medical Curricula. Strides Dev Med Educ. 2026 July; 23(1): e1756. doi:10.22062/sdme.2026.202580.1756

Keywords: Pediatric Education; Medical Curriculum; Psychosomatic Symptoms

Dear Editor,

This letter points out an overlooked educational deficit in pediatric training during a state of societal distress. During an evening in a pediatric emergency department during a period of military unrest in my area, an educational point began to become obvious in our clinical learning environment. Despite our prior expectations for a crisis setting, the pediatric emergency department was less populated with critically ill and critically injured children than we would have expected to be. Instead, we had a large number of children presenting to the pediatrics emergency department for symptoms of abdominal pain, difficulty breathing, palpitations, headaches, inability to sleep, nausea and behavioral irritability without explanation. Upon work up of the children in many of the listed presentations, we were largely able to document absent serious organic pathology and a clear temporal correlation with increased family and societal stress levels. These are qualitative observations. However, these experiences suggested a largely unrecognized gap in conventional pediatric medical curricula. Medical and pediatric students were skilled and were trained extensively to recognize and manage acute organic illness and emergency, but many were poorly equipped to deal with psychosomatic symptoms and anxiety-based physical symptoms in children. Bedside teachings often included discussion of ruling out organic illness, e.g. Differentiation of acute appendicitis from anxious functional abdominal pain, while comparatively little emphasis was placed on psychosocial history taking, communication with upset families and caregivers, identifying clusters of functional symptoms, or dealing with pediatric crisis anxiety. There is increasing attention in the public health literature (1, 2) that most children who were subjected to social unrest and military pressure demonstrated psychic reactions through somatic symptoms to a greater extent than through expressed fear and pain (3). Thus it is conceivable that periods of crisis could potentially impact significantly on the spectrum of clinical presentations in children's emergency services, and teacher schools' pedagogical and educational agendas. Inexperienced clinician faces a diagnostic problem, are unable to allay the worries of the caregivers, and are insecure on when to start on further tests. Lack of training in the use of those skill set may also result in needless testing, subsequent re- consultations or loss of confidence in what may constitute valid clinical explorations. While aspects such as trauma response and disaster readiness have grown in focus in disaster medicine curricula, the psychosocial aspects of pediatric crises have been under-addressed in many pediatric training programs relative to their physical trauma and readiness components. Multiple previous studies have shown the extensive negative psychological and behavioral impact on children from war and disasters, such as symptoms of anxiety, sleep disruption, and somatic symptom disorders (3). Discussions concerning

health in the context of emergencies over the last several months have also raised questions about the indirect effects of crises on underlying chronic pediatric disease processes, and on children's access to and utilization of care (2). This evidence suggests that the pediatric competence model of disaster preparedness must necessarily include the integration of skills and training in psychosomatic examination and communication. From a training curriculum standpoint, formal integration into the pediatric residency curricula will, even via current residency teaching methods, help prepare them for such experiences. By utilizing bedside teaching, simulation opportunities, dedicated communication education sessions, and interdisciplinary teaching with child psychiatry, clinical psychology, and medical social work, training might enhance confidence and clinical judgment when residents manage these instances (4, 5). Furthermore, education about psychological first aid, family-centered communication skills, and recognizing the functional nature of such symptoms within the Pediatric curriculum may result in better overall pediatric care during periods of communal unrest. Note that those societal and pedagogical impacts are not confined to conflict or disasters as such and can be seen during conditions characterized by long periods of internal instability and widespread concern for individuals, even without any evidence of societal physical collapse. Crisis pediatric training based on psychosocial aspects therefore needs to be an integral aspect of any standard pediatric training. A potentially less observed outcome of crises is likely that in many contexts affected children come to the clinic not necessarily with physical evidence of harm, but rather with the manifestations of distress and alarm. These children have issues as to how they can cope and adapt and what their parents should be aware of, revealing as well a clear void in the medical school curriculum, preparing them for these issues.

Acknowledgements: None.

Conflict of interests: No potential conflict of interest was reported by the author(s).

Ethical approval: Not applicable.

Funding/Support: None.

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