THE END OF PUBLIC HEALTH?

Since this book was published significant changes have taken place in the NHS which have further modified the public health function. Public health physicians are employed by health authorities, that is to say by the purchasers of medical care, and they are supposedly providing expert advice on health needs to managers. They themselves are certainly no longer managers nor is their advice necessarily followed. The latest attempts to redefine their responsibilities (in the Abrams report) only serve to demonstrate the strictly limited list of matters with which these consultants are now concerned.

The ground narrows and footholds are uncertain. Even the information base, formerly such a distinctive feature of the national health service and a boon to epidemiologists in this country, is in danger of becoming less accessible with the establishment of self-governing hospital trusts and the encouragement of trust status among GPs. Competition does not encourage sharing.

Yet a moment's reflection reveals that more and more people, both medical and lay, are today involved in health issues, in the fields, for example, of microbiology, reproductive technology, housing, agriculture, energy policy and environmental control. There even exists a 'New Public Health' movement and a 'Healthy Cities' project, although neither owes allegiance to the Faculty. A major challenge both for this country and for the USA must therefore be how to focus all kinds of new knowledge and expertise so as to effect sound public policies for health and the common good. Who will design the public health scene in the twenty first century? It will have to be on a much larger scale than today's diminished specialists are permitted for their local plans.

Because of the relatively low standing of their predecessors. the most recent cohort of public health physicians are likely to be extremely jealous of their full consultant status. In the face of diminishing numbers, however, there are already faint signs that they may shortly be obliged to think the unthinkable and to contemplate coming together, in a spirit of ecumenicism, with non-medicals. If this happens, the strange subtitle of this intriguing book will be truly applicable.

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THE WORLD SUMMIT ON MEDICAL EDUCATION

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The World Summit on Medical Education took place in Edinburgh on 8–12 August 1993, organised by the World Federation for Medical Education. The government reception by the Scottish Office, hosted by Lord Fraser of Carmyllie, was at the Royal College of Physicians. The precursor of the 1993 Summit was the WFME World Conference of 1988 which formulated the *Edinburgh Declaration*.[1] That conference identified the following 12 aims as the outcome of reform:

The provision of education in relevant settings
The basing of curricula on national health needs
The emphasis to be on disease prevention and health promotion
The establishment of lifelong learning
The basing of learning on competency
The training of teachers as educators
The integration of science with clinical practice
The selection of entrants for non-cognitive as well as intellectual attributes
The coordination of medical education with health care services
The achievement of balance in the production of different categories of medical practitioner
Training to be multiprofessional
Provision for continuing medical education

Reforms to these ends have been adopted in a number of medicals schools and found to be effective. The conservatism of the profession and the universities, and the complexities of the procedures involved in the production of the changes may be responsible for the slow response in the majority of medical schools.

The 1993 summit

The World Summit of 1993 faced new challenges to medical education arising out of global, social, and political change and new disease problems.[2] These include the increase in population in some countries; extensive shifts in national and regional political structures; economic recession; shrinking resources; wars and violence; the AIDS pandemic; the resurgence of diseases thought to be contained; health care systems in disarray, with costs rising out of control. Medical schools fall seriously short in their response to these challenges.

The widening task of doctors

Besides the promotion of health, the prevention and treatment of disease and the rehabilitation of the disabled, increasingly doctors have to learn to be better communicators. Among those qualified in medicine must now appear more critical thinkers, motivated life-long learners, information specialists, practitioners of applied economics, sociology, anthropology, epidemiology, and behavioural medicine; health team managers; and advocates for communities. These represent a greatly increased range of functions within the practice of medicine.

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TABLE 1
Primary themes of the Summit

i	The wider context: political changes, the economic state of the world and the needs and rights of patients.
ii	The medical profession in rapid change.
iii	The response of medical educators to meet the exponential growth of knowledge and technological advance.

TABLE 2
The twelve topics of the Working Groups

1	Professional attitudes
2	Teaching methods
3	Assessment and examinations
4	Sciences of clinical practice
5	Problem-based learning
6	Selection and admission to medical school
7	Governance of the curriculum
8	Specialist training
9	Continuing medical education
10	Integration of all phases of medical education with the health services
11	International collaboration
12	Recommendations of a summit *communiqué*

The setting in which doctors function has changed and their traditional role has been eroded: by diminution in access to care of the poor, unnecessary intervention for those with access, the spiralling cost of health care, the distortion of health care by market forces and by commercial inroads, and by capricious incentives promoting specialisation when generalists are more desirable.

The World Summit 1993

Besides the 250 medical educators and expert advisers who planned the meeting, five UN Agencies concerned with medical education and delivery of health care were co-sponsors: WHO, UNICEF, UNESCO, the United Nations Development Programme and the World Bank took part in the Summit.

The programme of the Summit had two components: *Plenary Sessions* which were chaired and introduced by main speakers dealing with the three primary *themes* (Table 1) and *Working Groups* for which twelve topics were selected; each Group related its topic to the sequence of themes dealt with in the plenary sessions (Table 2).

On its last day the Summit issued its *Communiqué*.[3,4] It outlined 22 recommendations[5] in five clusters:

A. Practice and Policy
B. The Educational Response
C. The Continuum of Medical Education [basic, postgraduate (specialist training), and continuing medical education]
D. Partners in Learning
E. Learning Settings

Each Recommendation was then examined in respect of the specific required reform, its recommended action, and the outcome to be expected from such action.

A. PRACTICE AND POLICY

1. Bringing together education and practice

Contemporary medical education demands a close relationship with the health care system which cannot be achieved in university hospitals alone. The disjunction when the medical education system is divorced from the health care delivery services, is still an unfortunate reality in many countries.

Action: The establishment of effective administrative and working relations between universities and the health services, including local health care organisations and communities. The skills acquired in reformed curricula must be relevant to the needs of the practice setting in the community.

Outcome: New political and institutional arrangements which will ensure relevance between education and the needs and patterns of practice.

2. Medical workforce planning

Countries should determine systematically the numbers of health workers required and, to achieve a balance, the competency profiles for each category.

3. Health care services: medical schools involved in development

Most health care systems are complex, costly, inequitable, and poorly understood by patients and doctors alike. Even doctors who receive a sound, innovative medical education may not find work satisfaction, due to unmet expectations of patients, problems of remuneration, excessive regulations, and more important, fundamental inadequacies in the health system. Health care systems need to be designed and implemented that are equitable, effective, and affordable.

4. Specialists and generalists: seeking a balance

An efficient and cost-effective health system must include generalists able to screen and treat most health problems, needing to refer only a small proportion for specialist care. Many developed nations have too many specialists and too few generalists. However, some specialties (such as psychiatry) may be underrepresented.

5. The health transition: educational preparation

The health profiles of the developed and developing countries are converging. Aggregated life expectancies in developing countries are high and also the toll of chronic disease of the elderly. The new social diseases (violence, drug abuse, family disintegration) affect vulnerable groups throughout the world. Medical education must reflect this transition.

6. AIDS and other chronic diseases

The effect of AIDS on communities, national health systems, and health care workers has proved devastating. The disease has revealed gaps in the preparation of doctors to cope with pandemics. These professional deficiencies have important applications to other more common diseases.

B. THE EDUCATIONAL RESPONSE

7. Medical school policy and institutional governance

Many medical schools have no mission statement. Some rarely review medical curricula which remain department driven and/or externally prescribed. Conceivably the absence of mission statements and the presence of nationally mandated curricula create passive institutions which in turn produce passive graduates. Administrative structures for planning and implementing curricular change are often lacking or unauthoritative, powerless to address many of the impediments to change; examination methods are often unrelated to educational goals.

8. Selection procedures for admission to medical schools

Medical school admission procedures should be based on the mission of the individual institution and its capacity, and on national health workforce targets. The open entry system is obsolete. Selection procedures are essential and everywhere endorsed, but at too many medical schools are arbitrary and, at worst, chaotic.

9. Medical teacher development for improved medical education

Medical teachers are often appointed mainly for their ability in biomedical research with little focus on their teaching and communication skills. Too many teachers lack the ability to help students grasp the concepts of biomedical, social and psychological sciences. There is justifiable concern that the poor learning habits of medical students are frequently compounded by lack of education expertise in their teachers.

10. Medical student involvement in planning and evaluating medical education

The role of students in their own education is vital. Students of today are the teachers of tomorrow. They should be involved in curriculum planning and teaching. Often more idealistic and less encumbered than teaching staff and administrators, they are potent agents for necessary educational change.

Action: Students should be valued as partners at every level of medical education: planning of objectives, medical school governance, curriculum teaching and evaluation.

11. Science in relation to medicine

Science lies at the heart of an effective curriculum. The methods of science are essential to defining problems and measuring impact of intervention in the care of both patients and communities. The teaching of science cannot be departmentalised and confined to preclinical years. The curriculum as a whole must reflect scientific method and critical thinking. Medical practice must be evidence-based.

Action: Department reconstruction which promotes horizontal and vertical integration of basic science, and incorporates the behavioural and social sciences in clinical and community health disciplines. Economic, statistical, managerial and informational sciences are relevant to clinical work.

Outcome: A multi-science-based practitioner who can remain abreast of advances and understand their relevance to the field of practice.

12. The ethical basis of medical education

The principles of ethics are applicable at two levels: in the clinic and hospital for the well-being of the patient, and, in communities, for the well-being of a population. Both call for comparable relationships: doctor to patient on the one hand, and health care provider to community on the other. Another, and newer, field of medical ethics concerns determination of priorities and allocation of resources in relation to needs.

Action: Ethics should receive full attention within the medical school itself, in all clinical encounters, and in the community.

13. Teaching and learning strategies and methods

Competence and motivation for lifelong learning is enhanced by effective learning methods. Problem-based learning sharpens the skills of analysis, synthesis, and evaluation, which are necessary for clinical problem solving. Training in the critical reading of scientific reports enables graduates to identify key advances in their own field. Community-based learning enhances relevance. Technological advances in educational methods, such as computer assisted learning, simulation and distance-learning, have roles to play in many settings.

Action: Educational institutions and associations should encourage active methods of learning which are student-centred, and promote the organisation of national and regional networks for the production of appropriate and relevant learning materials. Learning strategies should be competency-based and accord with local needs of health staff. Validation studies of assessment techniques and evaluation of innovations in the curriculum are required.

14. Curricular options for coping with information overload

Curriculum overload is an increasing problem in medical education, even if learning is enjoyable and students are capable and apply themselves.

Action: Working groups at international and regional levels should consider reviewing representative curricula. Innovations and reforms should include those based on systems teaching, and problem based learning, with differentiation of learning components into 'core' and 'options'.

C. THE CONTINUUM OF MEDICAL EDUCATION

15. Postgraduate medical education: a holistic view

The staffing for postgraduate education has to be in a context of overall requirements, otherwise excessive numbers of doctors with ill-chosen skills will be trained. There is need for a holistic view with policy-making mechanisms to produce balanced numbers of generalists and specialists. The postgraduate training programmes need to be carefully related to the local context in which they will be practised, and be linked in a continuum with undergraduate and continuing education.

16. Continuing medical education and lifelong learning

Continuing medical education is essential to maintain the competencies of newer graduates, to influence the practices of older graduates, to remedy practice gaps,

and to enable all doctors to respond to the challenges of the constantly changing professional environment.

D. PARTNERS IN LEARNING

17. Health teams and multi-professional education

Doctors alone cannot provide all health care. Contemporary doctors work in teams with many different professions represented. Learning together in teams and groups enhances early professional socialisation and provides opportunities for leadership development.

18. Participation of communities in medical education

Many initiatives are under way in different parts of the world, both developed and developing, towards community orientation of medical education, and community participation in determining health policy. Communities must be given an active part in decision-making and action for health. People have to be enabled to make the best possible choices, and have to be offered protection against preventable disease.

19. Communication with patients and public

Adequate communication skills with patients, colleagues and the public are basic necessities of clinical work. Dissatisfaction of patients and the public is due more to poor communication than to any other professional deficiency. Medical schools should identify how to improve communication skills in all students.

20. Wider participation in decision making to include the public

Communities seek to be better informed and to have greater influence over their health care system. Patients are entitled to more participation in and control over their individual care, which will make them increasingly responsible for their own health.

E. SETTINGS FOR LEARNING

21. Real-world settings for medical education

Medical education is typically hospital-bound, often concentrated on the tertiary level, and characterised by emphasis on rare diseases and expensive treatments. A range of learning environments, both medical and non-medical (workplace, schools, villages, households) will expose students to a more realistic array of health problems, human conditions, and professional role models, to enlarge and enrich their hospital experience.

22. Population-based medical education: commitment of universities

Medical education includes the epidemiological context of a patient's health, and liability to disease. Primary health care calls for equity: i.e. universal coverage and care according to need. Population-based education calls for those most in need, often on account of poverty, to be identified, with care provided for them which at present they do not receive.

INTERNATIONAL COLLABORATION

The call at the 1988 World Conference for a global collaborative programme was firmly endorsed. Only a responsible, effective partnership, in which all nations participate, can implement the many reforms recommended.

A partnership among all responsible organisations, associations, institutions and individuals must be formed, and this network must be charged to ensure that the Summit's recommendations receive proper debate, implementation, and monitoring. The World Federation, the co-sponsoring bodies especially WHO, UNICEF, UNESCO, UNDP and the World Bank, and all other bodies represented by their delegates at the Summit constitute the programme's organisational framework.

AFFIRMATION

The *Recommendations* of the Summit are now being further implemented at six Regional Conferences taking place during 1994–5, the venues as follows: Africa, Cape Town; Americas, Montevideo; Eastern Mediterranean, Al Ain; Europe, Athens; S.E. Asia, Bangkok; and the Western Pacific, Kuala Lumpur. Each of the six Regional Associations of WFME, with the corresponding Regional Office of the World Health Organisation, are co-sponsors.

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