

## Mandates for Medical schools

### Introduction

Human rights and the quest for equity and quality in health care are universal values. Thus, efforts to reorient health systems, social systems, and educational systems toward the achievement of a better state of individual and collective well-being deserve attention on a global scale. Change in medical education is to be seen within that perspective.

The pace of reform in medical education is quickening worldwide. Embodying this climate of change, the World Health Organization (WHO) is mounting a global initiative to facilitate the transformation of medical education into a more relevant, effective, and efficient enterprise in how it responds to society's health care needs. The WHO initiative "**Changing Medical Education: An Agenda for Action**" synthesizes many of the innovations in different parts of the world. These include problem-based learning, community-oriented learning, a population perspective in education, and the creation of university-community partnerships in the reform of health education and health services<sup>1</sup>.

Nearing the turn of the century, with growing understanding of shifts in power structure in health care and with a clearer understanding of determinants for change, one realizes that adjusting medical education has become inseparable from adjusting medical practice. New partnerships must be built, linking medical schools much more closely with the world outside their walls.

Likewise, the World Federation for Medical Education (WFME) has conducted since 1984 an "International Collaborative Program for the Reorientation of Medical Education".

### New challenges for medical education<sup>2</sup>

Doctors have traditionally held key positions in shaping and operating health systems and have enjoyed respect and deference from society. Nowadays, increasingly and globally, harsh competition erodes income, unemployment is rampant, medical decisions are contested and legal action is common, health policy decisions are controlled primarily by non-medical persons, and disillusionment with medical practice prevents the new generation from embracing the medical profession as enthusiastically as its predecessors did.



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### The Call for a New Medical Practitioner

Independently but with surprising unanimity worldwide, the call has arisen for a new medical practitioner.

1. Assess and improve the quality of care by responding to the patient's total health needs with integrated preventive, curative, and rehabilitative services
2. Make optimal use of new technologies, bearing in mind ethical and financial considerations and the consumer's ultimate benefit

3. Promote healthy lifestyles by means of communication skills and the empowerment of individuals and groups for their own health protection
4. Reconcile individual and community health requirements, striking a balance between patients' expectations and those of society at large, both short-term and long-term
5. Work efficiently in teams within the health sector and between the health sector and other socioeconomic sectors that influence health

The call for a new doctor is actually a call for fundamental change in medical practice and health care, which obviously will profoundly affect the nature of medical education.

### A New Mandate for Medical Schools

Medical education can be defined as the science and art of preparing future physicians to function properly in society, which should imply responsibility for influencing the circumstances and conditions under which they practice. To ensure durable impact of educational reforms, educational institutions must accept social accountability for their product.

With the need for more social accountability, a new mandate for the medical school is called for.

The terms community-oriented and community-based have been used to describe curricula that consider societal needs and the use of different levels of health settings in the community as learning opportunities. A trend toward greater social involvement has been noted in an increasing number of medical schools seeking to improve relevance in education.

Putting medical education in a wide public health

<sup>1</sup> Arthur Kaufman, Associate Editor, *International Medical Education*

<sup>2</sup> Charles Boelen, *Medical Education Reform: The Need for Global Action*

perspective may require three different kinds of adjustment on the part of medical schools:

1. There is political adjustment insofar as a medical school's new position on the health system chessboard must be negotiated and resources reallocated to help it fulfill the new mandate.
2. There is technical adjustment in the sense that medical schools would use their rich and diversified pool of talents to try new interventions for the optimal delivery of quality health service.
3. There is cultural adjustment, in that new habits and attitudes will be developed among academic leaders and staff that allow them to build bridges to the surrounding environment. It is probably on this front that the strongest resistance to change will come.

***The global agenda for change consists of three components:***

1. Defining and assessing quality medical education
2. Implementing strategies for change
3. Monitoring progress in change

### **1. Defining and Assessing Quality Medical Education**

Quality control is the rule for industries in most sectors. Shouldn't medical schools be held accountable for their products, which are central to health systems worldwide? Unfortunately, so far, the concept of quality in medical education has been left to various interpretations, and therefore proper and consistent program evaluation is difficult.

Quality medical education needs to be defined and measured with valid and reliable tools. Because the concept of quality depends on established values, its definition in the context of medical education will be very much influenced by the social mandate assumed by medical schools.

Indicators are therefore expected not only on educational content and process and on availability and use of resources, but also on how medical schools implement their social and health mission.

### **2. Implementing Strategies for Change**

Change cannot be induced the same way in every situation. Depending on the peculiarities of the political and socio-cultural context, several routes to change can be followed. These routes, or groups of related strategies, are not mutually exclusive

1. **Educational innovations.** Many of the innovations are intended to prepare students to think more critically and--through problem-solving methods--to decide what is appropriate for their own education and, it is hoped, for the society they intend to serve.
2. **Public health interventions.** This group of strategies stems from the concept that medical education must be conspicuously linked with an effort to improve the health of a given population.
3. **Joint ventures with medical practice.** By planning, implementing, and evaluating programs of continuing education with professional associations, medical schools stand to learn a great deal about what practitioners need to know in order to improve the relevance and quality of delivered care.
4. **Contribution to health services management.** Making health data readily available to a host of health care partners could facilitate cooperative action. The assumption is that educators and health managers could jointly come to devise the new practice patterns and changes in the education of doctors.
5. **A world sample of action research projects in medical schools.** Research is needed to expand our understanding of how such well-established institutions as universities and medical schools can be fundamentally reoriented to best serve society.

The 1,400 medical schools worldwide would benefit from lessons learned through research. A common framework would be needed to monitor the process of change.

### **3. Monitoring Progress in Change**

Global mapping of the progress of each change strategy, and the ability to retrieve this information through indicators that reflect the values of medical education, would be among the important functions of worldwide monitoring.

## **Fostering civic professionalism in Tomorrow's doctors**<sup>3</sup>

Michael E. Whitcomb<sup>4</sup> argues that if physicians are to meet their professional responsibilities to their communities, they must better understand the various ways that health care is organized, financed, and delivered in the country, and be more aware of the critical health policy issues facing legislators and other policymakers<sup>5</sup>.

Several other studies have documented deficiencies in the

<sup>3</sup> Adapted from an editorial by Michael Whitcomb

<sup>4</sup> Michael E. Whitcomb "Fostering Civic Professionalism in Tomorrow's Doctors"

<sup>5</sup> Muller, S. (Chairman). *Physicians for the Twenty-First Century: Report of The Project Panel on the General Professional Education of the Physician and College Preparation for Medicine. J. Med. Educ. 59, Part 2 (November 1984).*

understanding students and residents have about an array of health policy issues. And they are certainly in keeping with the results of an informal survey the Association of American Medical Colleges (AAMC) conducted to gain insight into how adequately health policy issues are presented in the medical school curriculum. That survey indicated that while some schools have attempted to provide some relevant content at various points in their curricula, a surprising number admit to having no formal approach to teaching students about health policy issues. Schools face two major challenges to providing meaningful instruction about the country's health care system and the health policy issues. Who will teach the material, and how will it be integrated into the curriculum? First and foremost, the leaders of our medical schools must make a commitment to ensure that their students receive appropriate exposure to the organization and financing of the health care system and to the key health policy issues the country faces. Most medical schools are not organized in ways that provide an academic home for an individual or individuals who are qualified to teach the material and interested in doing so. As a result, the typical medical school will have to reach out to other academic units of the university to supply faculty who are willing to teach the material to medical students, and the school will have to provide support for those faculty.

Second, the faculty and staff most directly responsible for the management of the medical school curriculum must be willing to see to it that appropriate material is integrated into the curriculum, and integrated in a way that will make its meaning most apparent to students. This goal is not likely to be achieved by limiting exposure in the students' early years. Medical students are always striving to understand the relevance of the material being presented to them. It will probably make more sense to integrate the material into the last two years of the curriculum, when students are actually involved in patient care.

## Conclusion

Physicians continue to be the gatekeepers to any health care system in the world. If policy makers are to make any indent into the reform of health care, physicians will need to "bank in" and be convinced of their duties and responsibilities. Although schools of public health and other faculties play an important role in supporting the new mandate of medical schools, the impact would be more accentuated if the departments of community medicine are to join in and be strengthened, as well as clinical departments in medical schools.

As is evident from the table below, there were 161 medical schools in the Arab world in 2006, 20x more than three decades earlier. The role of the community health departments (in medical schools) ought to be strengthened through a core curriculum that highlights the teaching of health policy, health economics, finance as well as

epidemiology. Deans of medical schools in the Region should consider this novel approach to impact on the medical students and graduates, the physicians of the years to come, if serious health reforms are to be considered and implemented.

Country	1950	2006
Bahrain	0	2
Djibouti	0	1
Egypt	3	26
Iraq	1	20
Jordan	0	4
Kuwait	0	1
Lebanon	2	6
Libya	0	24
Morocco	0	5
Oman	0	2
Palestine	0	2
Qatar	0	1
Saudi Arabia	0	12
Somalia	0	3
Sudan	1	30
Syria	1	6
Tunisia	0	4
UAE	0	4
Yemen	0	8
<b>Totals</b>	<b>8</b>	<b>161</b>

### Smoking in Pregnancy Linked to Psychotic Symptoms in Kid

The new research, published in the October issue of the British Journal of Psychiatry, doesn't prove that smoking during pregnancy causes the psychotic behavior, but it does suggest a link. In the study of 6,356 children in the United Kingdom, more than 11 percent of the 12-year-olds appeared to have definite or suspected symptoms of psychosis.

The researchers found that the children whose mothers smoked during pregnancy were more likely to have the symptoms, and the risk rose in those whose mothers smoked the most while pregnant.

Maternal alcohol use was also linked to more psychotic symptoms in children, but only among those whose mothers drank more than 21 units of alcohol a week during the early weeks of pregnancy (with one unit being roughly equivalent to a half-pint of beer or a glass of wine). The researchers couldn't find any link between maternal marijuana use and psychotic symptoms in children among the few women who reported using the drug during pregnancy.

The study authors suspect that tobacco exposure in the womb may indirectly affect the development and function of a child's brain, impacting impulsivity, attention or cognition.

"If our results are non-biased and reflect a causal relationship, we can estimate that about 20 percent of adolescents in this cohort would not have developed psychotic symptoms if their mothers had not smoked," study author Dr. Stanley Zammit, a psychiatrist at Cardiff University's School of Medicine in Wales, said in a news release from the journal. "Therefore, maternal smoking may be an important risk factor in the development of psychotic experiences in the population."

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