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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
World Conference on Medical Education

"Teaching Doctors to Teach"
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[Edinburgh Declaration attached]

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Background

The World Conference on Medical Education served as a fulcrum point in a process of transforming world-wide input on key questions regarding reform of the current medical education system into a set of recommendations for action which will be distinguished by unique high-level and global consensus.

The World Federation for Medical Education appointed a Planning Commission in 1984 to organize the considerable body of work which would precede the Conference. A set of key issues was explored at national-level meetings world-wide, and the findings of those meetings were reviewed and refined regionally before being consolidated into a global response which outlined recommendations and actions required for their adoption. It was this global response which was presented to the Edinburgh Conference – an invitational meeting attended by 150 participants such as deans of medical schools, ministers of health and education, leaders in the field of medical education, and the regional directors of the World Health Organization. The findings of the Conference will, in turn, be presented to the World Health Assembly in 1989, and it is anticipated that WHA *will refer a set of principles and recommendations for action to the six regions and their nations.*

The Edinburgh Conference, described by participants as an action-oriented conference, was an exceptional gathering. It was preceded by four years of preparatory work. The 'Edinburgh Declaration' issued at the end of the Conference, which identified twelve lines of action, pledges implementation of its recommendations at regional, national and institutional levels in the months immediately following the Conference, beginning with a series of meetings of ministries of health and education planned in each region to proceed with mechanisms and strategies of implementation.

It is a privilege and a special opportunity to be here today before this eminent audience, meeting on this important subject, in the homeland of my Scottish forbears (of more than two centuries ago), and sharing the opening session with my distinguished colleague, Dr. Hiroshi Nakajima, the new Director-General of that remarkable institution, the World Health Organization.

Medical education is a proud profession, and rightly so – with tremendous accomplishments to its credit in this 20th century. We all know, however, that no profession – no institution – can rest on its laurels in a rapidly changing world. The world-wide reappraisal leading to this meeting on the eve of the 21st century is thus especially welcome, and some would say overdue. I truly hope it will prove to be a 'World Summit' on medical education. Medical education in the 1990s needs to be judged by the needs and opportunities of the 21st century, when its graduates will live out their careers, and not by the needs of the 20th century, which is now passing behind us.

More than 50 years ago, my father, Dr. John B. Grant, a life-long medical educator with the Rockefeller Foundation who took the lead in establishing the first public health training institutions in China and India and in pioneering PHC, warned his colleagues that the most urgent problem facing the health community was the lag between modern knowledge and its use in the setting of a community. The two outstanding related causes of this lag in the health field are the lack of scientific investigation of methods to apply the results of the growing body of scientific knowledge to society, and the lack of training of health personnel to apply these methods. He went on to say that, as the principal instruments for generation, utilization and application of new knowledge are the universities, these institutions, and particularly medical education schools, bear the primary responsibility for the development of effective and scientifically based community health care. He strongly shared Dr. Abraham Flexner's view stated in 1910:

"The physician's function is fast becoming social and preventative rather than individual and curative. Upon him society relies to ascertain and to enforce the conditions that prevent diseases and work positively for physical and moral well-being".

Our failure still to adequately overtake that lag, a half-century later, is vividly demonstrated by the approximately 50,000 people – two thirds of them children younger than five – who will die prematurely *today*, and yesterday, and tomorrow, from readily preventable causes. The inadequacies of the medical education system of today bear a substantial responsibility for that lag.

I am glad to see that the report before us at this Edinburgh Conference clearly and commendably documents the needs and opportunities, and the revised course required for medical education to be truly relevant for the future.

This conference is poised at a crucial juncture in the history of medical education.

The World Federation for Medical Education has identified itself, in the opening words of the working document for this conference, as acutely aware of the widening gap between technical resources available for health care, and actually delivered health services "at least for substantial segments of the population". Thus we see some 4 million children still dying in 1988 because of the consequences of diarrhoea, much of which could have been readily prevented in the first place. Even in its later stages, the resulting dehydration could have been controlled effectively by low-cost oral rehydration therapy – a 'best' therapy which is not yet effectively embraced by the majority of doctors or hospitals or in medical education institutions in many countries including the United States and the USSR. We see the incidence of smoking still rising in most developing countries, when we already know that some 1 million people die prematurely each year primarily from this cause. These are dramatic illustrations of the gaps between

medical knowledge and its use for those who need it.

Your working document also draws attention to the fact that a main reason for this gap – the human consequences of which are the equivalent of a Hiroshima every two and one half days – is the manner in which doctors are prepared, and you note the allegation that "the ever increasing sophistication of medical diagnosis and treatment has diverted attention from the basic demands of primary health care to the more exciting and publicly admired challenge of delivering tertiary medical services".

The critical question before you is whether medical education will make the dramatic course corrections now required and identified, *or* whether lip service will be the order of the day, as so often in the past – and only incremental, inadequate improvements will be made.

Responsibility to the community

If we seriously aim to bridge the gap between available medical technology and its actual use by a population, one key question emerges for medical educators: *What is the responsibility of the medical community to the community at large?* Is the medical education system primarily responsible only for the quality of care to the individual patients a doctor attends? If so, does this profession effectively abandon to others those who fall beyond its immediate reach? Ultimately, it is the medical schools which decide who shall benefit from the knowledge you have accumulated. The schools decide by what is taught. As Dr. Nakajima said this morning, "Is it reasonable to demand that a graduate return to a general practice setting and address mostly preventive priorities when his training has been in a totally different milieu?" The significance of this question was dramatized by the Center for Disease Control (CDC) in Atlanta in the early 1980s when it noted that to add one year *medically* to the life expectancy of the average American male would require increased expenditures of several billions of dollars

annually, whereas 10 years could be added costlessly through his (1) stopping smoking, (2) moderating alcohol intake, (3) improving the quality and quantity of food intake, and (4) taking moderate exercise.

In most institutions, still, less than 1 per cent of medical education is devoted to topics such as community health and broad-scale health education for those who need to know. Is that the answer? Is that what the corporate medical community has decided by its actions – voting with its feet – that medical education does not include *health* education as a significant concern? That its overwhelming concern, and the principal concern of the doctors it teaches, are the patients who visit their offices, or are admitted to hospitals? Is there no major role for the medical profession – for the doctors it teaches, and the standards it sets – in the next great frontier of health progress, the frontier of health for *all* the world's people?

All of this is made more urgent, as Dr. Nakajima said in his inaugural statement last month, by the fact that:

> *"Nations have the technology – the cost-conscious options endorsed in our primary health care strategy – to fight today's inertia... and none of us needs sit on our hands.... What is needed is a reassessment of national and international priorities – a restructuring of the international conscience, accompanied by a redistribution of resources".*

Happily, the recommendations before this conference are taking the first steps in the field of medical education, and, if effectively adopted and implemented, can recapture the role of doctors as community and national *leaders,* rather than just medical technicians.

Reaching the unreached

What is the role of the medical school as the custodian of knowledge that is needed, but that much of

the community does not get? How, for example, can that knowledge be used to save and improve the lives of those who will *never* visit a doctor's office and will never see the inside of a hospital?

We have known for a long time that the use made of medical knowledge and efficiency of health protection depends chiefly upon social organization. This was among the conclusions of the landmark report of the Bhore Committee in India in 1946, and is among the main principles of primary health care codified 10 years ago in the Declaration of Alma Ata, in which the international health community declared itself committed to the goal of 'Health for All by the Year 2000.' Yet we have been slow in applying the principles of social organization to society as a whole, and to medical education institutions in particular.

The increasing communications revolution of recent decades – the ubiquitous radio, TV, schools in virtually every village, the explosion of modern marketing – has created new low-cost patterns of social organization which, combined with advances in low-cost health technology, offer a vast new capacity to extend health care far beyond the very limited domain of one-to-one, doctor-to-patient relationships – indeed, the whole world is within your reach.

The new potential arises from one of the most basic, and yet least acted upon, facts about human health in our times – the fact that almost all the major threats to human life and physical well-being are, at this point, more susceptible to informed actions by individuals than they are to further medical breakthroughs or even increased professional services, important as these may be.

Almost without exception, the major health threats of today can be most effectively combated by changes in human knowledge and behaviour. I have referred to the CDC comments about advancing the health of the average American male through change of behaviour. The toll among children could be at least *halved* by empowering people with what is already

known, and by supporting them in using this information to take greater responsibility for their own and their family's health.

Thus, it is clear that medical science now knows how to enable families to protect their children at low cost from the great scourges of diarrhoeal disease, measles, tetanus, whooping cough and acute respiratory infections – *the handful of causes which accounts for more than two thirds of the fourteen million child deaths in the world each year.*

If all parents were informed and supported in using oral rehydration therapy (ORT) when the need arises, in knowing the importance of a full course of vaccinations, in recognizing when respiratory infections threaten life, in knowing how crucial it is to breast-feed infants, to wean safely and to space births at least two years apart – then those parents themselves would be empowered to save the lives of approximately 7 million young children each year.

As a dramatic demonstration of the new potential of child survival activities in the 1980s, the lives of millions of children – reaching 2 million in 1987 alone – have been saved, and the crippling of millions more prevented, by people and nations which have mobilized to put today's low-cost solutions at the disposal of the majority of families in the context of primary health care. This is thanks in no small part to a growing 'Grand Alliance for Children' comprised of a vast array of professional groups including notably the International Paediatric Association; non-governmental organizations; community and religious institutions; organizations of government leaders – including, this summer, the Organization of African Unity (OAU) Summit, with 31 Heads of State participating, and the Moscow Summit of General-Secretary Gorbachev and President Reagan; and many, many others which are acting on behalf of children. This Grand Alliance would happily welcome the positive leadership of the medical education community as a whole – but, too often, it has had to act without, or even in spite of, the medical education system, despite the dedicated efforts of many gifted individuals within it.

It now becomes clear that, with a modest additional amount of commitment, it *is do-able* – by the end of this century, in twelve years – to reduce the 1980 child death rate by more than *half,* saving from death or disability in this process well over *one hundred million children* over the period, while slowing population growth as well, as families gain the confidence that the children they have will live. But full success will require a far more effective participation of the medical education community than at present.

Time to teach

Whether we are talking about the challenge of the major health threats in the industrialized world, or the greatest health problems of the developing world, or the new and universal threat of AIDS, the challenge is principally one of *informing and supporting people in applying what is already known.*

For the doctor to become the teacher of his community would be to return the title 'doctor' to its original meaning, namely, from the Latin *docere* – 'one who teaches.'

I was reminded recently by a wise friend that in the days of old every educated Chinese was expected also to be a doctor – to have studied the healing and medicinal arts of the day as part of being an educated person. Today the challenge is whether every doctor and everyone involved in the healing professions can also be, at least equally, an educator – 'one who teaches' – a 'doctor' in the truest sense.

I am very pleased to be able to share with you today that, in the task of bringing basic health knowledge to those who need it most, a major step will be taken later this year with the joint publication by WHO, UNICEF and UNESCO of a collection of 55 priority messages under the title *Facts for Life. Facts for Life* contains, in message form, the most important information now available to communicators to help parents protect their children's lives and growth. That

knowledge – organized under 10 topics such as the timing of births, the promotion of growth, the feeding of young children, the prevention of illness (including AIDS), the technique of oral rehydration, and the importance of full immunization – is knowledge which should now belong to all families everywhere. It is knowledge on which there is world-wide scientific consensus; it is knowledge on which most parents can act; and it is knowledge which has the potential to reduce child deaths and child malnutrition drastically. It is therefore knowledge which every family, by right, should have.

Facts for Life has made a special effort to present this in information messages which can be understood by all. Although the ultimate recipients are the families who must actually use the knowledge, the more immediate target is the broad spectrum of communicators of all kinds – community workers and groups, health and medical educators, schoolteachers, and all those who can help to put today's knowledge at the *disposal* of today's parents so that it can actually be used to save the lives and improve the health of those previously unreached by such benefits of modern progress. *Facts for Life* is, especially, a primer which doctors can use to *teach.*

The role of medical educators

How can the fundamental role of *teaching* health be restored to the physician? and of being responsible for the health of the entire community rather than for just a selection of individuals?

The global discussions fostered by this World Conference and reported in your working document put some strong answers on paper.

– Your question on 'The relationship to the community' brought the response that "Medical education must exploit a full range of settings for education, with the whole community and all its health service resources being employed...".

– Your question on 'Integration of medical education with health care' brought forth the response that "Medical schools should revise basic curricula to achieve balanced education in the community... in accordance with the concept of primary health care".

– Your question on 'Competence in community health' brought forth the *recommendation* that "Students must acquire the ability to promote health as well as deal with disease, not only in individuals but also in populations".

– The recommendation stemming from your question on 'Settings' was that "All medical students must be exposed to a broad range of learning environments that should range from rural health districts in the field to the urban tertiary care institutions".

I would add to this that medical schools must not only place students in a variety of existing community health care environments; they must take the lead in *designing, advising on, and creating* health care environments that actually meet the health needs of populations whose needs are now inadequately met. It is, in fact, in community settings that the most exciting research and teaching is possible – research into the health dynamics of the community, rather than into the pathology of just the patients in a hospital – working on solving the health problems of the community rather than discussing them in classrooms.

The historic medical breakthroughs of the coming years will occur not just in science laboratories. Just as important will be those 'laboratories' in which *the community* – not the individual – is the patient. The skills we must foster are those of treating the whole population. In addition to looking at the temperature, heart rate and enzyme levels of a patient, we must now measure the infant and maternal mortality rates, the nutrition levels, etc. We must

take health surveys, keep good records – and know how to use them. We must look at the overall environment in which ill health occurs. A primary role of the doctor will be to teach self-health activities and to promote social change for better care and prevention.

Fortunately, pioneering work in this approach to medical education is under way. Thus, there is a rapidly expanding number of schools in the Network of Community-oriented Educational Institutions for Health Sciences. Organized in 1979, the network now has 100 full, associate and corresponding member institutions which aim to make education for the health professions more relevant to the health needs of the communities they serve. It is these institutions which are putting people out in the community, reaching beyond hospitals. They are giving the community/field area an emphasis that is equal to that of the teaching hospital. Just as bedside teaching provided the major revolution in medical education in the last two generations, it is community-side teaching that today gives doctors the opportunity to contribute towards the world-wide goal of equity in health care.

In the 1990s – 80 years after Dr. Flexner's death – any medical school without a teaching district in the community comparable in importance to the teaching hospital of today will be abrogating its responsibility not only to society, but also to the doctors whom it trains.

The path is clearly defined in the recommendations before you. The challenge is to follow it.

What is next?

Am I an optimist or a pessimist as to the capacity of medical education to respond adequately to these challenges – to these new opportunities? I like to be optimistic, but I should note that history tells us that normally – not always, but *normally* – severe crises are required to provide the tremendous energy necessary to overcome the inertia of prevailing

policies. Thus it took the Great Depression to achieve the breakthrough to the New Deal in the United States. World War II preceded the establishment of the United Nations and the Bretton Woods institutions – and the World Health Organization and UNICEF. Closer to home in your own profession, in China, only during the 1960s were the rudiments of primary health care effectively brought to the vast majority of the people, but at great societal cost – including the closing of most medical schools.

What are the consequences, you may properly ask, of medical education not becoming far more relevant to future needs? Nothing dramatic for doctors, but a continuing loss of status as leaders in their communities and in their self-respect. The worst consequences are for the tens of hundreds of millions who will die prematurely, and for the larger numbers who will suffer needlessly. And if these are in fact reduced by intervening leadership from other sectors, the role of doctors will move more rapidly towards that of technicians, not leaders. It may be noteworthy that among the 435 members of the US House of Representatives today, only one, I am informed, is an M.D.

Is the medical community wise enough to make the hard choices now which would ensure its continuing leadership role in society's health in the 21st century – or will its inertia compel an underserved society to take education for health in the community into other hands?

Ten years ago, the historic Alma Ata conference recognized the challenge and charted a revolutionary course seeking to mobilize all for Health for All by the Year 2000 through primary health care. Can we now count on this Edinburgh Conference to fully enlist the medical education community in this great cause?

A revolution in medical education will be required to seize the new opportunities for Health for All. I join Dr. Nakajima in urging you to lead the way, and I pledge all appropriate support from UNICEF as you do so.

THE EDINBURGH DECLARATION

The aim of medical education is to produce doctors who will promote the health of all people, and that aim is not being realized in many places, despite the enormous progress that has been made during this century in the biomedical sciences. The individual patient should be able to expect a doctor trained as an attentive listener, a careful observer, a sensitive communicator and an effective clinician; but it is no longer enough only to treat some of the sick. Thousands suffer and die every day from diseases which are preventable, curable or self-inflicted, and millions have no ready access to health care of any kind.

These defects have been identified for a long time, but efforts to introduce greater social awareness into medical schools have not been notably successful. Such facts have led to mounting concern in medical education about equity in health care, the humane delivery of health services, and the overall costs to society.

This concern has gathered momentum from national and regional debates which have involved large numbers of individuals from many levels of medical education and health services in most countries of the world, and has been brought into sharp focus by reports which followed from the six regions of the world and which address the basic issues. It also reflects the convictions of a growing number of doctors in teaching and clinical practice, other health professionals, medical students, and the general public.

Scientific research continues to bring rich rewards; but man needs more than science alone, and it is the health needs of the human race as a whole, and of the whole person, that medical educators must affirm.

Many improvements can be achieved by actions within the medical school itself, namely to:

1. Enlarge the range of settings in which educational programmes are conducted, to include all health

resources of the community, not hospitals alone.

2. Ensure that curriculum content reflects national health priorities and the availability of affordable resources.
3. Ensure continuity of learning throughout life, shifting emphasis from the passive methods so widespread now to more active learning, including self-directed and independent study as well as tutorial methods.
4. Build both curriculum and examination systems to ensure the achievement of professional competence and social values, not merely the retention and recall of information.
5. Train teachers as educators, not solely experts in content, and reward educational excellence as fully as excellence in biomedical research or clinical practice.
6. Complement instruction about the management of patients with increased emphasis on promotion of health and prevention of disease.
7. Pursue integration of education in science and education in practice, also using problem-solving in clinical and community settings as a base for learning.
8. Employ selection methods for medical students which go beyond intellectual ability and academic achievement, to include evaluation of personal qualities.

Other improvements require wider involvement in order to:

9. Encourage and facilitate co-operation between the Ministries of Health, Ministries of Education, community health services and other relevant bodies in joint policy development, programme planning, implementation and review.
10. Ensure admission policies that match the numbers of students trained with national needs for doctors.

11. Increase the opportunity for joint learning, research and service with other health and health-related professions, as part of the training for team-work.
12. Clarify responsibility and allocate resources for continuing medical education.

Reform of medical education requires more than agreement; it requires a widespread commitment to action, vigorous leadership and political will. In some settings financial support will inevitably be required, but much can be achieved by a redefinition of priorities, and a reallocation of what is now available.

By this Declaration we pledge ourselves and call on others to join us in an organized and sustained programme to alter the character of medical education so that it truly meets the defined needs of the society in which it is situated. We also pledge ourselves to create the organisational framework required for these solemn words to be translated into effective action. The stage is set; the time for action is upon us.

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