

Training doctors for the year 2000

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Summary. The World Health Organization's strategy, Health for All by the Year 2000, presents a challenge to those responsible for training doctors. Doctors are needed who are concerned to promote health not just treat disease. A review of the medical undergraduate curriculum is required to achieve this. We describe a small step towards this by the restructuring of a community medicine teaching programme so that students are introduced to health promotion and the principles of Health for All.

Key words: *education, medical, undergraduate; *forecasting; community medicine/*educ; England

Introduction

The recent World Conference on Medical Education in Edinburgh (World Federation for Medical Education 1988) highlighted the need for a review of the medical undergraduate curriculum, especially if we are to meet the challenge of the World Health Organization strategy, Health for All by the year 2000 (HFA 2000) (World Health Organization 1981).

The British Government is now committed to pursue the goals of Health for All and its three main tenets: the promotion and facilitation of healthy lifestyles; a reduction in the burden of preventable ill health; and the reorientation of health care. These initiatives have potentially far-reaching implications for the medical profession. They presage major changes in medical practice and in the organization of health care and thus the nature of medical practice in the future.

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This was emphasized by the Edinburgh Declaration (*Lancet* 1988), which states that 'The aim of medical education is to produce doctors who will promote the health of all people. . .'. However, even if medical schools accept this goal, it raises the question of how medical students will respond to such a change in orientation of the curriculum. Past experience is not encouraging as it is admitted that 'efforts to introduce greater social awareness into medical schools have not been successful'. The World Conference on Medical Education outlined actions which medical schools as a whole should take; much can also be done within individual departments to implement the recommendations which the conference set out in its International Collaborative Programme for Reorientation of Medical Education.

We report on how the Health for All by the Year 2000 strategy has formed the basis of the teaching in community medicine in Liverpool and on how the medical students have reacted to this focus. The aim was to introduce the concept of the doctor's role and responsibilities in public health, seen as a first step towards a more radical orientation of the undergraduate curriculum which would place more emphasis on the teaching of social sciences and make primary health care the main source of clinical learning.

The community medicine programme

For several years community medicine has been taught as a 1-week unit within the third-year programme. Students have completed between one and three clinical attachments before embarking on this 1-week course. It was seen by students as a circumscribed and separate unit with little relevance to clinical medicine. Attendance was compulsory and guaranteed by an examination at the end of the course. Teaching

comprised mainly lectures and tutorials in aspects of epidemiology with implications for clinical practice, e.g. routine statistics, epidemiological research methods and screening. Other activities during the week included a visit to a medical department and workplace of one of the big Merseyside industrial organizations for an introduction to occupational health. Students also completed an essay on a given subject such as immunization or screening.

New programme

The whole structure of the teaching block was revised following the 1987 Faculty of Community Medicine Summer Conference 'Equity — A Prerequisite for HFA 2000'. It was suggested during the meeting that undergraduate teaching in community medicine had failed to encompass HFA 2000. This provided a stimulus for the reorganization of the course, especially in view of Liverpool's participation in the Healthy Cities project, which is involved in bringing HFA 2000 to city level (Ashton *et al.* 1986). Coincidentally, the course had been increased to 2 weeks from 1986 to 1987, thus allowing more flexibility in arranging the programme though still providing very little teaching time out of the 5-year course. This impetus was maintained by the Committee of Inquiry into the future development of the Public Health Function recommending that the General Medical Council (GMC), medical schools and other training bodies . . . 'should review their education and training programmes in the light of their recommendations and the need for renewed emphasis on public health issues' (Acheson 1988).

The course devised maintained the commitment to basic epidemiological skills by lectures and practical sessions but added more relevant and practical illustrations of public health issues, though these had to be selective because of time constraints. After an introduction to the concepts of HFA 2000, lectures and tutorials were organized around the themes of the specific targets. For example, target 1, 'Reducing inequalities in health', was covered by a lecture and discussion of the major reports on health inequalities followed by a city planner describing urban inequalities in Liverpool. Similarly, a session on target 3, 'Better opportunities

for the disabled', consisted of a sociologist's perspective of disability, a community physician's survey of the needs of the physically disabled, which was prompted by the Royal College of Physicians' (1986) report 'Physical Disability in 1986 and Beyond' and two members of a self-help community group talking about their needs and how they were meeting them.

Other targets were considered: target 24 on 'Healthy housing' included a visit to the city planning department and a field visit to look at housing around the city and visiting the Eldonian village (an award-winning housing cooperative). Target 25 on 'Healthy working conditions' allowed a visit to a factory and a seminar on health and safety, occupational health services and unemployment and health. In addition, students were introduced to local health promotion initiatives such as the syringe exchange scheme for drug injectors. The environment and its relationship to health was considered, for example, by evaluating the use of open spaces in the city, reflecting the prerequisites for health outlined in the Ottawa Charter on health promotion (World Health Organization 1986).

A health service manager described the relevance of Health for All in planning and providing appropriate health services. This included an introduction to the concepts of efficiency and effectiveness. Public health aspects of issues which concern clinicians were also discussed. These included AIDS, screening services, in particular the general introduction of mammography for early detection of breast cancer, and the consequences of differential resource allocation. The course ended with a lecture on international community health.

One of the strengths of the course was that intersectoral cooperation could be demonstrated by having lecturers and tutors from the local authority, health authority, workplaces and voluntary agencies. Hopefully, this will encourage students to appreciate the contribution that many different groups may make to health. Similarly, community participation in planning and developing services was evident when students met various community groups.

The course is repeated three times during the year with one third of the 150 students attending each block. During each block there are four

tutorial groups of about 13 students. The Department has a professor, two senior lecturers, a lecturer and a senior registrar in community medicine available for teaching. In addition, there are a lecturer in health promotion and two medical statistics lecturers, as well as general research staff, e.g. an economist and psychologist. As mentioned previously additional teaching support is provided by staff from other organizations.

The course is examined by a 1-hour written examination (essay question) at the end of the 2 weeks. The question is distributed the previous night. However, there is also a compulsory question in the final MB examination as part of the clinical medicine paper. Furthermore, the Head of Department participates in the clinical and oral final examinations. Through this public health questions can be introduced into the clinical setting.

Evaluation

Students were asked to evaluate the content of the course at the end of the unit by commenting (anonymously) on the value and interest of each session and the course as a whole. In general all teachers in the department agreed that the restructuring had given the course more cohesion and relevance. Students were more participative in tutorials, taking a keen interest in some of the issues. The evaluation at the end of the course confirmed the impression that the nature and content of public health was better understood than previously. Most students had never heard of HFA 2000 at the beginning of the course, though by the end they had a good understanding of the basic principles.

Our first attempt was not without problems. Some students had difficulty accepting the need to look at housing or the environment as determinants of health, suggesting that it was all common sense anyway. Some were dissatisfied that awareness of issues had been raised but not enough time devoted to possible solutions. Other comments included '... made me think for the first time in 2 years. ...' and '... it was a surprisingly worthwhile and interesting course. ...' (this perhaps reflects some preconceptions of community medicine!) The course was also very time-consuming to organize and dependent on the cooperation of many different people.

Discussion

It is difficult to predict what kind of health service will be operating in 10 years' time. From today's standpoint there is general agreement that the health-care environment will change. Already public health and preventive medicine have greater importance, as clinical medicine becomes more affected by political, managerial and financial considerations. Surprisingly, the undergraduate curriculum has not, so far, taken these changes into account. Many medical students are unaware of the climate in which they will ultimately be practising. One way of addressing this is to use HFA 2000 to change the focus of the curriculum. As already stated this should be for the whole medical school to act on not just within a 2-week course out of a 5-year training programme.

In the meantime, the community medicine course will continue to be modified according to the students' responses. It is hoped to introduce different skills such as problem-solving. A new development has been the introduction of interdisciplinary learning by having 25 Bachelor of Nursing students attending the course in 1988–89. We recognize that the course as it is now can only give students a flavour of health promotion and prevention.

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