REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

Fourteenth Session

Agenda item 10 (c)

REVIEW OF SOME ASPECTS OF MEDICAL EDUCATION
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I</strong> INTRODUCTION</td>
<td></td>
</tr>
<tr>
<td>1. General Consideration</td>
<td>1</td>
</tr>
<tr>
<td>2. Regional Situation</td>
<td>1</td>
</tr>
<tr>
<td>3. The Work of the Eastern Mediterranean Regional Office in Medical Education Up to Now</td>
<td>2</td>
</tr>
<tr>
<td><strong>II</strong> SOME PROBLEMS IN THE FIELD OF MEDICAL EDUCATION</td>
<td>3</td>
</tr>
<tr>
<td>1. Reasons why Medical Education has become so important</td>
<td>3</td>
</tr>
<tr>
<td>2. The Role of the Medical School and the Medical Student</td>
<td>4</td>
</tr>
<tr>
<td>3. The Objective of Medical Education</td>
<td>6</td>
</tr>
<tr>
<td>4. Medical Manpower</td>
<td>7</td>
</tr>
<tr>
<td>5. Aspects of Medical Education which cannot be dealt with in Present Paper</td>
<td>9</td>
</tr>
<tr>
<td><strong>III</strong> TEACHING OF PUBLIC HEALTH, PREVENTIVE AND SOCIAL MEDICINE</td>
<td>10</td>
</tr>
<tr>
<td><strong>IV</strong> THE FUTURE REGIONAL PROGRAMME IN MEDICAL EDUCATION</td>
<td>13</td>
</tr>
<tr>
<td>1. General Considerations</td>
<td>13</td>
</tr>
<tr>
<td>2. Specific Proposals for Action by the Regional Office</td>
<td>14</td>
</tr>
</tbody>
</table>
I INTRODUCTION

1. General Consideration

Medical education is a very broad subject, on which only certain aspects can be presented to this session to give an impression of the magnitude and importance of the problem. The public daily experiences problems associated with the need for enough doctors to serve individuals and communities. Public health administrators are especially concerned with the availability of the right type of doctor at the right place. The medical college, as a rule, is little or not at all concerned with problems beyond its walls. Medical educators do not always know the problems which the doctor has to face nor how well he is doing his job.

Education in medicine is the product of scientific development in advanced societies in the last hundred years. It is oriented toward problems which are totally different from those of the countries of this Region. Here we are faced with large and poor rural populations where agricultural techniques still rely heavily on manual labour rather than mechanized tools. Malnutrition and infectious diseases are the most common causes of pathological conditions and high infant mortality is the best indicator for the physical and social state of affairs.

2. Regional Situation

During the last twenty years there has been rapid progress in all social and economic sectors. This movement has also affected the medical schools. Responsible public health administrators, medical educators and, last but not least, politicians have been and are concerned with the shortage of trained personnel.

Emphasis is placed on the need to increase and speed up the production of medical and paramedical personnel whereas the problem is less one of numbers than one of new concepts and fresh orientation towards realistic goals in a changing society. While in 1940 there were in this Region eight medical schools in seven countries, there are at present thirty-three medical schools. This impressive expansion, it should be noted, almost exclusively concerned countries which already had medical schools. Iran increased their medical schools from one in 1947 to six in 1963; Pakistan went from one in 1948 to fourteen in 1964; the United Arab Republic rose from one in 1942 to six in 1963. Much of the progress, therefore, occurred in three countries
which contributed twenty-three out of the total of twenty-five new schools.

Iraq has had a medical college in Baghdad since 1927 and established a second one in Mosul in 1960. Israel created its first medical school in 1949 and its second in 1963. Ethiopia and Tunisia are now actively establishing medical schools and it is expected that they will be thrown into full operation in 1964.

Those who witness this evolution are impressed by the great efforts the countries have to make themselves, regardless of any assistance offered and used. Difficulties are even greater with the first school established in a country.

3. The Work of the Eastern Mediterranean Regional Office in Medical Education Up to Now

The work of the Regional Office in the field of undergraduate medical education can be divided into the following stages:

3.1 Until 1958: Individual visiting professors in only a few instances were supplied to some countries (e.g., Iraq and Pakistan). In addition, two medical teaching missions (to the United Arab Republic in 1955 and Iran in 1957), each consisting of ten professors, were organized by WHO Headquarters.

3.2 Until 1962: An attempt was made in 1950 to carry out a survey of all medical schools in the Region to determine their major problems in preparation for a conference on medical education. At the same time medical consultative groups were sent to countries where medical schools were to be established for the first time or where special problems existed. These groups were appointed to study the situation thoroughly, to discuss local problems with all concerned, and to prepare a report with their recommendations. The medical education consultative group consisted basically of three experienced professors (one in a major clinical subject, one in the basic sciences, and one who represented public health and preventive medicine). Others may occasionally be added if and when the circumstances make this necessary. Up to now four such groups have successfully operated in this Region. In addition to overall problems two special consultants thoroughly

---

1See Proceedings of the Conference on Medical Education in the Eastern Mediterranean Region; Teheran, 16-24 October 1962.
explored the special problem of medical school libraries.

With this material in hand, and with the assistance of additional consultants, the Conference on Medical Education in the Eastern Mediterranean Region was then held in Teheran in October 1962. The Conference reviewed the whole complex problem of medical education as seen by public health administrators and medical educators in this Region. The published report set out its findings and thoughts in all major areas in this field.

Since that time it has become apparent that the Conference succeeded in stimulating medical educators and public health administrators to review critically the many problems common in this area. At the same time it was suggested that the Regional Office should carry out a more active programme in medical education and review progress and needs from time to time.

3.3 From 1963: With this start an attempt followed to keep the movement in medical education progressing. A Special Group Meeting on Medical Education, composed of selected regional experts met in December 1963 to discuss the major events that had taken place since October 1962. It was further asked to advise the Regional Office on what action could in the future form a part of its programme in medical education, particularly with reference to those portions which needed Government action. The report of this group has been published and distributed under "Report on Special Group Meeting on Medical Education, Alexandria 16-20 December 1963 (EM/SP.MED. EDUC./8)". Furthermore, a training course on medical librarianship (for librarians in medical school libraries) was held in Beirut from mid-August to mid-September, 1964. Another inter-country activity planned for 1965 or 1966 is a course on medical pedagogy.

II SOME PROBLEMS IN THE FIELD OF MEDICAL EDUCATION

1. Reasons why Medical Education has become so Important

It is worthwhile to consider the reasons for the rapidly increasing emphasis on medical education during the last decades. The problems underlying this gain in momentum have been well summarized in one of the introductory speeches delivered at the Conference in Teheran and it seems appropriate to quote the relevant part:

"It is necessary and urgent to emphasize and to make widely known that medical education is rapidly becoming a matter of great national importance and national responsibility and is not a mere sideline of medicine and of higher education, that somehow almost automatically produces medical graduates. Several factors responsible for this rapid evolution can be singled out:

1. The wide acceptance of the concept that the right to health is one of the fundamental human rights has broadened and deepened the social function of medicine, but it also implies new responsibilities of society with regard to medicine.

2. The rising costs and expanding machinery of medical care make it an important sector of the national economy and absorb a sizable and increasing proportion of the national income.

3. The growing role of planning in the development of all nations necessarily influences the requirements with regard to medical manpower and education.

4. The rapid growth of the scientific bases of medicine and the progress of their practical applications require an intensive initial education as well as lifelong study.

5. The changes in the organization and circumstances of medical work require adequate orientation, preparation and adaptation of the physician.

6. The cost of medical education is a heavy burden to the community, with many important implications for all concerned. The sum of 10 million dollars is often considered necessary for the establishment of a medical school and 1 to 2 million for its annual budget (without maintenance of a hospital).

2. The Role of the Medical School and the Medical Student

Problems in medical education are continuously arising. One of the most pressing, certainly a matter of great concern, is the question of the overall role of the medical school or college. Is it sufficient just to teach the student facts and skills, some of which will never be applied? The scientific approach to medical practice is desirable but it is extremely difficult for a general practitioner (especially if he is looking for a better income) and virtually impossible for his poorer relative, the rural practitioner. Does or should the medical school care about the fate of its graduates? Can it be concerned with his performance in the community, whether in his scientific, social or ethical responsibilities? Have the graduates of medical colleges been fully prepared for all of the problems in isolated rural areas, or is there even a graduate to go there?
What opportunity is given at any level of training for a doctor to become familiar with pathological conditions, social problems, or environmental conditions characteristic of rural areas in this Region?

We know that 75% of the population is living in rural areas in most of the regional countries. It is obviously important that the future doctor be trained to contribute to the health and welfare of that overwhelming majority of the population. What does the medical teacher know about rural problems? Is this even a part of his teaching? Has the professor of surgery demonstrated to students how to work in the conditions of a rural hospital, or does he himself know?

These and many other questions have contributed to the growing conviction that the whole concept of the medical school requires re-thinking and re-shaping. The walls of the medical school need to be penetrated, making possible its union with the entire community. The surrounding geographic and social structures need to become a part of the training ground just as it needs to be effectively served by the graduates of these medical schools.

Students are faced with a constantly increasing amount of scientific knowledge, and even with the establishment of new disciplines in medicine. The educator is faced not only with the burden of introducing the increased data into a badly crowded curriculum but also with the problem of getting it into the heads of the students. Medical educators are complaining more and more about the deficiencies in the scientific preparation of the students in secondary schools; they also criticize the low standards of general culture (humanities) of the medical student and young medical doctor.

As Sir Charles Illingworth recently declared: "Human diseases leave no time for the humanities, and the only culture we know is the bacteriologists' broth" ¹ Addition of general culture subjects is under consideration by medical schools, extension of pre-medical studies in scientific fields by others. The medical course faced with a growing body of scientific knowledge may need strengthening through additional time and the practical experience

¹Medical Education, a plea for Initiative and Experiment - by Sir Charles Illingworth. The Lancet, No 7328, 8 February 1964.
as part of the education process, in the opinion of some medical educators, may need more than one year.

What should be done in this situation which is progressively increasing in its complexities? The means of teaching and learning may need review and modernization. Teaching aids may lead to more efficient use of students time and increase the effectiveness of the academic staff. Drastic changes within the present curriculum may allow more economical use of time; this may be done by multi-discipline teaching by organ systems, or by some other new technique. Can the medical educator alone cope with this situation? How can he be guided in his efforts, and still survive the harrassment of an ever-increasing number of student admissions?

The most logical approach is through research in medical education itself. Carefully planned experimentation is an integral part of the purely scientific activities of medicine but has not been used in the equally problem-ridden subject of medical education itself. Thus far there has not even been an objective evaluation of existing systems of teaching.

The special meeting on medical education made an attempt to define the role of the medical school as follows:

a. To provide life-time education for the physician;
b. To conduct medical and related research;
c. To serve as an example of medical care of the highest obtainable standard;
d. To provide assistance to the community in the planning and training of the auxiliary and paramedical personnel required to meet community needs at its current stage of development;
e. To participate in the overall planning of health and medical care.

It is evident from this definition that the group was fully aware of the need for expanding the realm of responsibility of the medical colleges and, in fact, emphasized the need for the colleges to meet that responsibility. They further recognized the need to use every influence to gain wider support for the greater task envisaged.

3. The Objective of Medical Education

The objective of medical education is a basic consideration which needs careful and continued attention. If well conceived it provides the educator
and the educated a common goal in their efforts. Is the existing objective consistent with the primary needs of the total community?

Western concepts of medical education have contributed greatly to the present goal of medical education. As a consequence there is a growing tendency to prepare the student for specialization rather than for serving his fellow-men as a practitioner. Curative medicine and a high income go hand in hand. Education today makes the student feel inadequate for any practical or responsible activity, leaving him convinced that he needs further sheltered experience and greatly specialized skills. At the Teheran Conference the concept of the "basic doctor" was heavily stressed. These and other considerations led to a definition of the objective of medical education which is fully oriented towards the conditions of this Region, as follows:

"The objective of medical education should be to develop a broadly educated person, who is motivated with the desire to serve his country and possesses the human qualities of devotion to duty, kindness, tolerance, patience and compassion; the future physician must also possess a wide knowledge of the social and economic conditions of his country and the world at large, and be equipped with adequate knowledge of basic medical sciences, preventive medicine and clinical subjects; he should be imbued with a desire to keep up his studies and be capable of undertaking training for specialization. He should have received practical training in clinical and rural health work, for at least one year. There should be provision for the training of specialists in accordance with a ratio based on the needs of the community as determined by a national planning board. Specialist training should be undertaken only after the graduate has had not less than two years of practical experience in general duties involving intimate contact with routine medical and health work.

The view was also expressed that it might not always be feasible to place restrictions on the subjects of specialization or the stage at which the individual begins the specialization course, more particularly in the case of those who contemplate advanced studies at their own expense".

4. Medical Manpower

Another important aspect which needs consideration and which is of high ranking priority, especially for the public health administrator, is the question of medical manpower. Although this was fully discussed at the conference, only a few aspects will be emphasized now. One of these is the need to consider quality more than quantity as a measure of manpower resources. The widely used doctor/population ratio provides a rather distorted perspective and is never fully illuminating. What then are the problems involved in
medical manpower?

One of these, to which reference has already been made, is quality. The right type of service requires the right type of doctor, one who has been prepared for the work he is expected to perform. To achieve the best results there must be close collaboration between medical schools and the Ministry of Health. Furthermore, training must be reviewed constantly in light of the needs of the community and with reference to community demands. This deserves the full attention of experts in social medicine and sociology as well.

Medical manpower evaluation is meaningful only with accurate assessment of the distribution of doctors. For one country of the Region the figures available show that about 70% of the population live in rural areas but 95% of the doctors are in urban areas where they serve the remaining 5%. As a consequence only 5% of the medical manpower is available for two-thirds of the population. Obviously, a concentration of medical facilities is bound to be found in the cities but the proportion of doctors serving the rural areas is disproportionately insufficient. Many devices have been attempted to correct this disproportion.

One plan has been the posting of interns or recently graduated doctors in rural areas for a specific period of time, from one to several years. Practice in an urban area is not allowed until this service has been completed. As an emergency measure this has the single advantage of providing medical service in rural areas where it is otherwise not obtainable. It has serious disadvantages as well. It offers the people in rural areas the most inexperienced medical care. Furthermore, because it is a forced period of service, the doctors usually leave as quickly as possible for a location of their own choice. The rural areas deserve the most experienced doctors, those who have a high level of devotion to their patients, but these are rarely available.

Another administrative technique has been the use of various inducements to attract doctors to needy areas. These offers have included higher salaries, special allocations, housing facilities, etc., but they have not been very effective. Possibly the best plan is for the extension of medical schools themselves into the rural areas. There they will find specific scientific, psychological and social problems which are excellent for teaching
and for providing the budding doctor with the right kind of challenge. It may also help him realize that medical service is not separate from the other needs of his country, that what he does professionally should be a part of many related national efforts in a developing economy. Certainly various measures need to be combined in some new fashion. The best plan will depend on close collaboration between governments, medical schools, and educators.

To make effective use of his knowledge and skills, the doctor should have the assistance of auxiliary and paramedical personnel. Where there are less nurses than doctors in a country, good medical care is not possible. There is an additional need for various professional and auxiliary personnel for the services which are indispensable for medical and health care by modern standards. To be realistic, planning for medical manpower must include the needs for these personnel. There must be a careful assessment of the available overall resources from secondary school graduates. There must also be an evaluation of both the public and private sectors with an estimate of the eventual distribution of all personnel. Obviously, medical manpower planning, vital for all developing countries, require a multiple approach. It must combine the efforts of medical educators, public health administrators, and other planners including economists, sociologists and public administrators.

5. Aspects of Medical Education which cannot be dealt with in Present Paper

Apart from these general considerations which are of particular importance for the public health administrator, a discussion on medical education is bound to centre on questions more directly related to the medical curriculum. The experience of all conferences and meetings have shown that these are important problems, especially for the medical educator. These subjects have been extensively dealt with in the report of the Teheran conference. The most relevant chapters which deal with topics other than the broad ones of the objectives of medical education and manpower are: requirements for admission to medical school and selection of students; medical curriculum and methods of teaching; assessment of progress and system of examinations; staff requirements; internship and residency training programmes, postgraduate training and research; organization and administration of training institutes and inter-institute relationships. These intricate subjects will be omitted from the present discussion while we turn to the teaching
of public health and preventive medicine.

III. TEACHING OF PUBLIC HEALTH, PREVENTIVE AND SOCIAL MEDICINE

The preceding discussion makes it apparent that it is now important to consider carefully the teaching of public health, preventive and social medicine. WHO firmly believes that this subject deserves a special place in our thinking in any discussion of medical education. It has become of generally increased importance everywhere but particular efforts are being made in this Region to give it all the weight it needs. In 1961 a limited group of countries, partly from this Region, partly from outside, met in Shiraz, Iran, to attend a seminar on teaching of preventive medicine. The report is available and provides interesting material. Pakistan held a national conference on the teaching of public health in 1963 and made important proposals for changes in the undergraduate curriculum. The most important of these was the establishment of a department with a full-time professor and appropriate supporting staff.

It is fully realized that, as they are now taught, public health, preventive medicine, and social medicine are neither the most attractive nor the most important subjects for the medical students. In order to have a clear concept of their meaning, which still varies, reference is made to definitions which are summarized below:

Preventive Medicine - an approach to various stages of health and pathological conditions, particularly with the individual as its primary goal, but in certain situations with the approach made to wider groups. Preventive medicine has been separated into three phases or areas of activity.¹

a. The prevention by biological means of certain preventable diseases such as acute communicable and deficiency diseases;

b. The prevention of some of the consequences of preventable or curable chronic diseases, such as syphilis, tuberculosis, cancer and diabetes;

c. The prevention or retardation of some of the consequences of non-preventable and non-curable diseases, such as many cardiac ailments.

¹Smith G. and Evans, L.J.: Preventive Medicine, Attempt at Definition, Science 100:39, July 21, 1944.
Social Medicine - is a scientific approach and technique to evaluate the influence of social factors and phenomena on individuals or groups of people affected by certain pathological conditions. This approach stresses the close inter-relationships involved between psychological, physical and social conditions in the production of a healthy or diseased state.

Public Health - has been defined as "the science and art of preventing disease, prolonging life, and promoting health and efficiency through organized community effort for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of diseases and the development of the social machinery to ensure for every one a standard of living adequate for the maintenance of health — so organizing these benefits so as to enable every citizen to realize his birthright of health and longevity."\(^1\)

Only a few points will be dealt with here regarding the very complex problem of teaching public health, preventive and social medicine. This entire subject is still imperfectly understood by public health administrators, medical educators, and doctors in general. An effort worth mentioning to improve this situation was a meeting held by WHO Headquarters in August 1963. This was an Expert Committee on the Promotion of Medical Practitioners interested in Preventive Medicine.\(^2\)

The three fields mentioned above should be the responsibility of a department of public health, preventive and social medicine, in a medical school. Such a department is a newcomer compared with the traditional fields such as surgery and medicine, and is generally much less spectacular. Like all newcomers it must convince the older members of its importance to the students and of its value to the academic family. It is especially important that it demonstrates the place it deserves in a scientific environment, that it produces its results through scientific methodology, and that the results of research are valuable not only to the department itself but to the entire promotion of medical knowledge. Unfortunately, the scientific approach has been poorly developed in some phases of public health, but the possibilities

---


for useful work are almost unlimited. These will be discussed later.

Careful consideration must also be given to the method of teaching. Classroom teaching, especially lecturing, has lost its importance and is certainly not the attraction of past years. Previously those professors who understood best how to present their subject were forcefully the most appreciated. We are now in a period of shifting emphasis from the classroom to the laboratory, from the auditorium to the ward, from the patient presented to the large audience to the out-patient cubicle where the student works and is taught through his own participation, banishing the distance between him and his subject. Similarly, it is of utmost importance for public health to develop attractive and realistic "laboratories", that is to say, to use also urban and rural centres for discussion and presentation of problems which are of direct concern to the medical student.

Whether the student is to become a practitioner, a specialist, or a public health doctor, he should associate the care of a patient or a group of patients with his total environment, especially the family, in order to develop a realistic perspective. Emphasis should not be only on the cure of a disease but also on the positive approach to the maintenance of good health under the various physical, biological, psychological and social influences of an environment with which he is at present unfamiliar either through education or personal experience. He must learn what cannot be learned in the laboratory or hospital.

A related point of importance is the need for both the student and the professor of public health to discover the means for using the team approach to their problems. The professor must show that he cannot teach public health alone. He is dependent on those who also participate in teaching in the field and on those who are needed for other critical services. These include the bio-statistician, the sanitary engineer, the health educator and the public health nurse. With this team the classroom will no longer be separate from the community, and sources of information will be brought together in a comprehensive whole. The best of scientific approaches to problems in public health must utilize bio-statistics, various surveys, and the tools of epidemiology. A department of public health and preventive medicine can make a great contribution to medical schools by teaching statistical methods, a subject in which it is expert and which is often a point of weakness in the research studies of scientific medical groups, inside and
outside medical schools. Through this kind of approach public health teaching has established itself as a respectable activity in many institutions.

It is extremely important also to recognize the role which must be played by departments other than preventive medicine in the study of all aspects of social or medical pathology. The professor of public health not only has to broaden his own team approach to teaching but he must also join in conferences with clinical and basic science colleagues to develop bases for common interests. Even more important, all the medical instruction, and especially the clinical one must be oriented in such a way that the prevention of disease occupies a prominent part in the discussions of disease problems. It is not sufficient to consider diagnosis, etiology, and treatment, but one must also consider the preventive and social aspects involved in relation to the entire community. In the clinical conferences, there should be routine participation by the physiologist, the biochemist, the anatomist, certainly the professor and his staff in public health and preventive medicine, and others. It would be a great step forward if clinical specialists would also participate directly in the teaching of preventive medicine, thus supplementing the skills of the professor himself who, in turn, would be an experienced public health officer. This kind of cross-fertilization is obviously useful, and will enhance the prestige of the department of public health in relationship with the clinical divisions.

From the foregoing it has become clear that effective teaching in preventive medicine is an expression of the attitude of the entire medical school, that it is a matter of total integration among academic personnel who believe in the need for disease prevention.

IV THE FUTURE REGIONAL PROGRAMME IN MEDICAL EDUCATION

1. General Considerations

Medical education is expensive. It requires an investment in teaching hospitals and laboratories, in the recurring expenditure for staff (various levels of teachers, paramedical, professional, technical and auxiliary staff), equipment, supplies, books and journals. One country in the Region found that the yearly cost to educate a medical student abroad was about $1 300 whereas the cost in a medical faculty within the country itself was about $4 000 per year. A student in a science faculty in the same country costs about $1 300, in a faculty of arts $600, in a faculty
of law about $450 per year.

Educationally and financially, a great responsibility lies on the governments which undertake the creation of new medical schools. It is needless to say that WHO, within its policy, can only offer advisory services and assistance in training staff in a variety of forms. However, as these types of services are generally of great importance in the development of new programmes and methods, of which some may involve substantial expenditure, especially at crucial points in the development of new policies, it becomes therefore essential that WHO provides a variety of services not only to those countries with medical schools but also to those which do not yet have them. This paper will not enter into details of WHO assistance to medical education either to countries without plans now for establishing medical schools or those with definite plans. These countries will continue to be assisted in the traditional and well-established manner through consultative groups on medical education and with fellowships for the preparation of future staff.

2. Specific Proposals for Action by the Regional Office

The main programme in medical education which needs further development and elaboration concerns the countries which have already medical schools established. The Special Group Meeting on Medical Education which met in Alexandria from 16 to 18 December 1963 considered very carefully a number of possibilities which were discussed by the Group and the Secretariat. Previous consideration had been given within the Secretariat to the activities which might be developed; on the basis of these discussions and previous work specific proposals were outlined and accepted by the Special Group in the report which has been made available to governments.

These specific proposals will serve as a guide-line for the development of future programmes. It is expected that some of them can and will be realized in the near future. They are:

2.1 Regional Consultative Group on Medical Education

It is proposed to establish a consultative group to enable the Regional Office to call members individually or in groups whenever the need arises in order to ensure continuous contact with outstanding medical educators.

\[\text{Report of the Special Group Meeting on Medical Education, Chapter IV, pp 15-16.}\]
in the Region. A full-time medical officer to act at the same time as medical education adviser in the Region will have particular responsibility for contact with and assistance to this group. The consultative group will have the following responsibilities:

a. Assist in the formulation of minimum standards of medical education, including standardization of minimum pre-medical requirements;
b. Advise on hospital standards, particularly those of teaching hospitals;
c. Advise on medical curriculum;
d. Advise on recruitment of faculty members;
e. Advise on policies;
f. Assist in exchange of faculty members of different schools in the Region to increase contact among colleagues and to learn about one another's research and educational interest and problems;
g. Assist in planning short-term fellowships to Deans and senior teaching staff to go to centres within or outside the Region to study current trends in medical education.

2.2 Regional Information Centre on Medical Education

It is proposed to establish an information centre within the Regional Office to serve not only as a direct link between the members of the consultative group and the Regional Office, but also as a direct link between medical schools and the Regional Office. Most specifically, it should provide a number of services for the benefit of medical educators and teaching institutions in the Region such as:

a. Publish a Regional Medical Directory and Calendar of events in medical education containing names of senior faculty members, their background and qualifications, and their fields of interest. This would facilitate communication among individuals with similar interests. Other teaching institutions may also be included as well as a list of conferences and events pertaining to medical education in the Region and elsewhere. References may also appear on important and recent publications on medical education;
b. Supply reprints of articles that are needed for research and other projects of faculty members in the Region;
c. Advise medical investigators on possible sources of support for research from other agencies;
d. Circulate abstracts of research in progress in the Region;
e. Circulate information on training courses and educational opportunities;
f. Announce available vacant positions in educational institutions, if so requested by the institution.

2.3 Encouragement and Support of Model Medical Faculties in Member Countries

The Special Group on Medical Education dealt in detail with the idea of having at least one, but preferably more, model medical schools established in the Region. This school would strive for excellence and serve as an experimental centre in medical education, testing new ideas on pre-medical training, admission standards, examinations, curricula, research, employment of full-time professors, post-graduate education and general policy decisions.

It is evident that WHO cannot establish medical schools and it was therefore felt that Member Governments, particularly those who have a number of medical education institutions, might be interested to use one of the existing or soon-to-be founded institutions as a model medical school. Such institutions should preferably be located in areas where integrated services already exist or can be readily effected among various health agencies and the medical school. In such a setting, social, economic, and medical problems should be studied in their various interacting relationships.

2.4 Libraries

Many medical schools need assistance in obtaining new medical books and periodicals either because of paucity of funds or shortage of foreign currency. On the basis of its present policy, WHO can assist - upon request of governments - in the procurement of books if foreign currency is not available in sufficient amounts, by facilitating the use of local currency for this purpose.

The need for well-trained and well-informed medical librarians is equally important and has to precede the material expansion of libraries. For this purpose, the Regional Office is organizing in 1964, for the first time, a training course on medical librarianship.

2.5 Text-books

Previously, during the Teheran Conference, a proposal was made that WHO should actively assist in the provision of cheap editions of standard
medical text-books through exploring the following possibilities:

a. The willingness of publishers to ship the unbound sheets of text-books to individual countries where they can be put together and bound locally, thus reducing overall prices;
b. The availability of special editions of text-books in cheaper forms;
c. The production of medical text-books of sufficiently high standard by publication within the Region.

2.6 Design and Planning of Medical School Facilities, including Teaching Aids

The expansion of already existing medical schools as well as the creation of new institutions requires considerable planning and careful studies to make the most economical use of time and money. There are already important publications by WHO, the United States Public Health Service and the Association of American Medical Colleges that could be used as sources of reference for the design of medical schools and laboratories. Although these references are very helpful, they should be supplemented by free exchange of ideas between the Deans and the faculty members concerned and their experienced colleagues abroad.

WHO may provide funds for experts to visit institutions where such planning is in progress. Similarly, WHO may provide funds for two or three responsible planners of a new medical school or other teaching institution, to make a tour of existing institutions to gather information on different approaches and prevailing ideas. This will not only serve to enlighten the educators concerned but to ensure that the large sums of money for construction and equipment will be advantageously spent.

2.7 Inter-Country Co-operation

The Special Group on Medical Education considered to what extent and in which form medical schools and medical educators could co-operate, not only in solving their own problems, but also in supporting the efforts of WHO - limited as it is in staff and funds - to arrange for inter-country collaboration. It was felt, although this subject could not be sufficiently explored, that it would be advisable to pursue the idea of a Regional Association of Medical Educators and that perhaps the Special Group or its individual members might initiate action in this direction in the near future.