WORLD FEDERATION FOR MEDICAL EDUCATION

Telephone: 031-226 3125
Telex: 727442 (UNIVED G)
Fax: (031) 667 7938

President:
**Professor H.J. Walton
International Medical Education
The Medical School
University of Edinburgh
Teviot Place
Edinburgh EH8 9AG
Scotland, U.K.**

7 October 1988

Dear Colleague,

With the full agreement of the Chairman of AMEE I have great pleasure in sending you a copy of the Report of the World Conference on Medical Education.

The Programme of the World Federation now enters an extremely active Implementation Phase. The organizational framework on p. 44 of the Report indicates the great role to be taken by National Associations for Medical Education.

The World Federation for Medical Education and AMEE therefore seek your most active participation in making the text of the Edinburgh Declaration on pp. 8-9 and the conclusions of the World Conference on pp. 39-44 widely known to medical schools in your country, to other educational bodies, to professional associations and to your Ministries of Health and Education.

There will be a very considerable responsibility to be carried out by your national association in the immediate future. You will know that a Regional Ministerial Consultation, bringing together Ministers of Health and of Education of all European countries is being held in Lisbon on 31 October - 2 November 1988.

Please let me know if you require additional copies of the Report for wider circulation. You will note the price per copy on the last page.

With good wishes.

Yours sincerely,

Henry Walton

H.J. WALTON
President

Enclosure : Report of the World Conference on Medical Education

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 organised 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.

12 August 1988
World Conference on Medical Education of the World Federation for Medical Education
sponsored by
World Health Organisation, United Nations Children's Fund, United Nations Development Programme, City of Edinburgh, Lothian Regional Council, Scottish Development Agency.

REPORT OF THE CONFERENCE

Introduction

Four years of planning, numerous discussions at country level, and six Regional Conferences culminated in the World Conference on Medical Education aimed at global reform in the education of doctors. In a field notorious for slowness to change, what were the prospects that change would come now, even after four years of meticulous planning with extensive involvement of concerned parties at every level and every stage?

The participants were optimistic, even confident, that substantial change in the orientation of medical education towards greater relevance to the needs of their societies would follow. One reason for that optimism had to do with the stage of the process represented by the World Conference where two important steps were taken. One was a statement of intent to move with all seriousness and commitment, expressed in the Edinburgh Declaration. The other was to move from concept to strategies for action, which was the major undertaking of the Conference.

A further reason for believing that progress towards re-orientation would follow was the feeling by many participants that such changes were truly necessary, unavoidable and urgent. Some would go so far as to say that if changes were not undertaken by those responsible for medical education, that they might lose the opportunity to do so and that others would then take the initiative, as a result of public demand

STRATEGIES FOR ACTION

While the duration and structure of the Conference were not intended to develop full strategies for action, illustrative strategies were formulated, incorporating steps that would have to be taken at the medical school itself, and at national, regional and global levels.

Formulating strategies for fundamental change in medical education is a complex undertaking. One reason for this is the requirement to involve multiple parties in achieving change in an area where self-interest is intense and deeply rooted. Another reason has to do with the wide range of support required by medical schools as they try to move onto new ground.

The process of planning for the World Conference had already covered a great distance in strengthening or establishing such supportive arrangements. There was an evolving understanding of how medical schools would interrelate with national, regional and global supportive programmes as they strive toward reform.

The four levels—medical school, national, regional, global—differ substantially in their roles and contributions to reform in medical education. The participants addressed them all, each level in turn, and then their interactions and synthesis. What has emerged can be called an International Programme for Support of Reorientation in Medical Education.

A central tenet of this effort is that further international collaborative programmes for effective support of change in medical education will have to be established.

ACTION AT THE INSTITUTIONAL LEVEL

The major part of the effort to promote re-orientation in medical education toward the health needs of society is ultimately to be expressed at the institutional level in terms of modifications of educational programmes relating to the training and further continuing training of doctors, and also as these relate to service and research responsibilities.

Without resolve to change at the institutional level, little will transpire, whatever the external pressures. Given interest in change within the institution, then an international programme of support can be highly effective.

The participants identified a series of issues that might be raised by the institutions themselves in opening up the possibilities of change:

1. Assess the current medical educational programmes in terms of their relevance to the health needs of society.
2. Consider the congruence of the medical educational programme and the health and health manpower policy of the country.
3. Review with medical teachers and students their willingness to undertake such assessments, and to do so collaboratively with those responsible for the national health services.
4. Assess the role the medical school can play in collaboration with the national health services in planning the future of those services and in the implementation of those plans.
5. Assess the possibilities of shifting the settings for learning so that community-based and hospital-based settings are used in a balanced way.
6. Consider the curriculum and teaching methods in terms of the extent to which they involve problem solving rather than didactic methods.
7. Consider incorporating the training of teachers in teaching methods as an integral part of development of teaching staff.
8. Assess the rôles doctors of the future might fill in providing care to deprived populations, including working with community people and other health

workers in planning and managing comprehensive primary health care programmes, and whether their current competences correspond to their future rôles, including the leadership rôle they would have in such programmes.

9. Consider ways in which medical students could work together with students of other health professions in order to strengthen the potential for team work.

10. Consider the forms of external support that would facilitate proceeding with these changes.

11. Consider the steps necessary to bring teaching staff and students to a readiness to deal with such issues.

12. Give thought to advocating the need for change to the public and to leaders in policy making.

Consideration of these issues constitutes the first steps of institutional reform. Having identified which of these steps they would undertake, institutions would then move toward development of plans of action, including defined targets and time frames.

ACTION AT THE NATIONAL LEVEL

While all levels are important, action at the country level is particularly so. On the one hand, interactions between national health policies and medical education, and between service and research are worked out at this level, involving concepts crucial for ideas of common interest between university programmes and national needs. On the other, regional coherence is considerably strengthened by joint national political commitment, thus paving the way for concerted global action.

In countries with multiple medical schools, there is the potential for collective action in identifying priority problems and actions in which institutions are encouraged to initiate reforms and National Associations of Medical Education provide essential support. The national organizations may either provide support directly or draw on further assistance from regional and global bodies.

The Discussion Groups at the Conference probed deeply into the components and dynamics of reform at the national level. Among other contributions they developed a prototype of planning for change at the country-level. The following list of strategic steps might not be required by all countries; rather, the list might be seen as a series of steps from which countries could consider which apply to them:

1. Specify the major problems facing the medical schools in the country, such as: lack of relevance to health service requirements; over-production of doctors in relation to national health manpower requirements; laboratory and lecture room-based and hospital-centred learning; excessive emphasis on teaching to passive students; inadequate knowledge of teaching staff of problem-based learning methods.

2. Identify the overall goal and directions of re-orientation.

3. Based on the above, identify major areas for action and targeting:

   a. Formulate a medical education policy in the context of the national health and health manpower policy,and ensure their continued interaction.

   b. Develop a health manpower plan and a medical education system that is responsive to the needs of the country in terms of the quality and number of graduates and fields of practice.

   c. Establish a national coordinating mechanism to link the education of health personnel to other relevant sectors, including non-health sectors.

   d. Encourage interactions between medical schools and other departments or divisions of the universities to achieve common goals in health development.

   e. Promote the development of medical education so as to ensure commitment and support from:
      - leadership in policy making
      - professional associations, licensing bodies, medical councils
      - practicing health professionals
      - teachers
      - medical students
      - health services personnel and managers
      - communities.

   f. Facilitate exchange of information and expertise regarding changes in medical education within the country.

   g. Conduct research in medical education to refine understanding of the problems and to support policy formulation, implementation and evaluation.

   h. Identify educational programme reforms to be undertaken at the institutional level, such as:
      - extend settings for education to community and other non-hospital sites
      - modify curriculum content to make it more relevant to national health needs
      - modify teaching methods to emphasize problem based learning, including in community settings;
      - incorporate the team approach in both health services and learning experiences of students;
      - incorporate learning of new skills, such as computer literacy.

   i. Review student assessment procedures and criteria and consider modifications so as validly to assess performance, and to support learning.

   j. Review administrative mechanisms and

structures of medical schools and consider modifications to facilitate the change process.

k. Develop the teaching staff needed by improving:
   - teacher selection
   - ongoing training of teaching staff
   - support of career development
   - work conditions
   - incentive systems

l. Incorporate into assessment and promotion systems rewards for teaching staff for interest and creativity in dealing with needs for change.

m. Develop indicators and milestones, and monitor changes in medical education.

n. Promote and carry out inter-country co-operation share information and experiences.

o. Encourage interactions between medical schools and other departments or divisions of universities to achieve common goals in health development.

ACTION AT THE REGIONAL LEVEL

The World Conference provided a special opportunity to organize discussions along regional lines, and to extend action plans developed earlier within the regions toward strategies for implementation.

A key issue has to do with how Regions will organize their approaches to re-orientation of medical education. Regional Associations of the World Federation for Medical Education, together with Regional Offices of WHO, and other interested parties will form collaborative arrangements to address the imperatives for change.

In each of the six Regions the current approach to reform of medical education had been assessed and further steps needing to be taken specified. While the regions differ greatly in their circumstances, the actions follow similar patterns. Here can be given examples of the kinds of actions required to promote and support change, which the proposed International Programme will be expected to carry out.

Organize Interactions:

1. Ensure linkages among national associations and through them with their medical schools.

2. Develop and maintain linkages with relevant regional and global bodies-governmental and non-governmental.

3. Convene Ministerial Consultations in all six Regions as an immediate follow-up to the World Conference.

4. Convene meetings with deans of medical colleges, directors of health services and other appropriate parties.

Assess and Monitor Problems and Monitor Reforms:

1. Collect and disseminate information relevant to problems and reforms.

2. Establish a regional task group to review reforms and monitor changes.

3. Develop indicators and milestones for monitoring changes in medical education.

4. Promote self assessment by institutions.

5. Analyse apparent obstacles and resistance to reform, and develop appropriate strategies.

Develop Capacities for Advocating and Supporting Change:

- develop materials and other resources that can be supportive of changes
- curriculum materials
- components of health care system relevant to student field experience
- examples of changes being attempted elsewhere
- consultations
- traineeships for teaching staff
- seed money for projects
- travel money to see other examples
- develop strategy to sensitize teaching staff to need for change
- maintain inventory of supportive resources available in regional institutions.

Develop Projects:

1. Initiate multi-institutional research on effectiveness of curriculum changes, such as community-based education.

2. Formulate projects involving several institutions in undertaking reform, possibly involving comparisons of results, and facilitate obtaining project-based funding.

Mobilize Resources:

- look to national, regional and global sources for resources e.g. WFME, WHO (or facilitated by association with WHO); foundations; regional international organizations, bilateral agencies and private philanthropy.

ACTION AT THE GLOBAL LEVEL

A number of supportive relationships between medical schools and organizations that function internationally at the global level have an historical basis, and these have been strengthened during the several years of preparation for the World Conference. New relationships also have been established, and for all of these interactions, there are new dimensions in the direction and commitment to change.

A number of organizations and agencies will have critical roles to perform:

1. WFME, in close liaison with WHO and in open collaboration with other interested parties, will serve in a coordinating, guiding and catalytic rôle. It will maintain a broad view of medical education internationally, co-ordinating implementation of the overall action plan expressed in the Declaration. It will promote the development of arrangements to support change at regional, national and institutional levels, and co-ordinate the monitoring of those changes. There will be an avoidance of duplication of efforts that are already underway, and an effort to function in complementary ways so as to promote optimal use of available commitment, interest and resources.

2. WHO will continue to play a key rôle in promoting re-orientation of medical education, in keeping with its mandate as the international co-ordinating health agency of the world, working together with its 166 member states for the goal of health for all through the primary health care approach. It will function through its global-to-region-to-country structures, through its critical relationship to health policy and health services development internationally, and by virtue of the trusted position it has in relation to countries and intergovernmental, non-governmental and bilateral agencies.

3. UNESCO has indicated its interest in participating in supportive arrangements for programmes of change, and will be able to facilitate access to Ministries of Education and also, through the International Association of Universities, to universities. UNDP, UNICEF, UNFPA and the World Bank are other UN agencies with strong potential for assisting in this effort.

4. The Network of Community-Oriented Educational Institutions for Health Sciences is an available resource consisting of institutions with actual experience in innovative community-oriented education, and would be an important participant in this effort.

> *WHO will continue to play a key role with its mandate from 166 member states in its goal of health for all mainly through improved primary health care*

5. Student organizations, such as the International Federation of Medical Students' Associations, have especially important roles in bringing student perspectives and advocacy capacities to this effort.

6. Other groups have important potential roles to play, including the International Association of Universities, the Council of International Organizations for Medical Sciences, etc.

7. Several foundations and sponsoring bodies have indicated the possibilities of assisting the development of these programmes.

8. The range of activities at the global level is similar to that at the regional level, including:
   - organizing interactions
   - assessing problems and monitoring progress of change
   - advocating and supporting change
   - developing and supporting projects
   - mobilizing resources

CONCERTED ACTION

While each level has its particular rôle to play, it is quite clear that effective steps must be taken at each of the four levels if this ambitious effort to bring about substantial change in medical education globally is to succeed.

It will be when the four levels—medical school, country, region, global—are functioning in concert that substantial progress can be realised:

1. At the institutional level, medical schools can be helped to see the need to change and supported in their efforts to change, and their experiences, both successes and failures, can be communicated with others.

2. At the country level congruence between the health care needs of society and medical educational programmes should be promoted.

   The institute responsible should be encouraged to undertake reforms and Supporting Services be made available.

3. At the regional level, support and encouragement can reach out to national associations of medical schools, informative interactions among schools and countries can be facilitated, support for change can be generated, and progress monitored, with feed-back coming from institutional and country level as to the problems and progress.

4. At the global level, with an overview of these activities, it will be possible to promote support where needed, to capitalise on successful efforts to change, and to maintain an agenda of actions, focussed particularly on emerging and unresolved problems, that will keep the effort current and dynamic.

The Edinburgh Declaration calls for widespread commitment to action, vigorous leadership and political will to alter the character of medical education so that it meets the needs of the society in which it is situated. The world leaders in medical education who participated in the Conference at Edinburgh thoroughly demonstrated these qualities, and were spirited in their commitment and readiness to proceed to implement the actions which they and their colleagues at country and regional level put forward. While change may have come slowly in medical education in the past, there were reasons to be optimistic that the quality and strength of resolve expressed over the past four years of preparation and at the Edinburgh Conference would accelerate change and strengthen the impact of reform to the benefit of the world's people.

The strength of resolve, already growing, to improve Medical Education has been much enhanced by the World Conference and bodes well for the impact of reform

THE PATH AHEAD

The ground is prepared. Extensive work by committed people and agencies over recent decades, and the four year preparatory period leading to the World Conference on Medical Education, have built a foundation for major advances against problems in the field of medical education.

The Edinburgh Declaration has been issued, strategies for action are being formulated regionally and nationally, inter-ministerial meetings involving both ministers of education and health are planned, an inter-agency task group of WHO, UNICEF and UNESCO is being formed, funding is being sought, and increasing numbers of institutions and individuals in all six regions are exploring possibilities of action for change in their own settings.

How can these efforts be given coherence? What kind of organizational frameworks might be developed that would promote and facilitate rather than stifle change?

PRINCIPLES AND ORGANIZATIONAL FRAMEWORKS

To begin, it is well to outline some principles to guide the development of organizational frameworks that were called for in the Edinburgh Declaration.

The most important organizing principle is that definitive action should, wherever possible, emanate from the medical educational institutions themselves. It is there that the impact on medical students and on programmes for post-graduate training and continuing medical education will be made, or fail to be made. There, too, will be the definitive locus for addressing institution-based problems of change in medical education. And it is there that many of the most important solutions to tomorrow's problems will be worked out and then shared with other institutions and other levels of the global effort. Here, then, is the principle of independent and flexible initiative coming from the bottom and proceeding upward through the international organizational frameworks. To put it differently, this is not the place for top-down prescriptions.

But, of course, few if any institutions will be able to address the needs for change independently and without support. The most important supportive resource will be at the national level. Here will be the interactions with national health and health manpower policies, with political and public figures, and with other relevant groups and organizations. Here, too, will be a collective effort of the medical schools to share experiences, refine understanding of problems, and join together in addressing those problems. The national level will also provide nodal points for interaction with regional and global supportive efforts.

Definitive action should, wherever possible, emanate from the medical educational institutions themselves. It is there that the impact on medical students and on programmes for post-graduate training and continuing medical education will be made, or fail to be made.

Regional and global supportive efforts are, ultimately, intended to reach the medical schools and post-graduate and continuing medical educational programmes through the intermediaries of regional and national organizations. Here, the principle involves support coming from the top down, in response to requests from the national and institutional levels, or to draw attention to problems which appear to be receiving too limited attention.

An important characteristic of this international effort, which adds complexity but has great potential strengths, is pluralism. Multiple organizations, agencies, groupings and individuals are involved in grappling with problems of medical education, some deeply committed and greatly experienced, others more peripherally related but with potential for greater and more effective involvement. Given the diversity of these parties, it is unlikely that a single organizational framework will either attract or contain them. Thus, the Edinburgh Declaration wisely speaks of organizational frameworks.

The principle here has to do with making best use of these interests in order to have beneficial effects at the level of medical educational programmes.

Organizational approaches should be taken that will provide opportunities and encouragement for interested parties to participate in this international effort, either in collaboration with others or independently but constructively, depending on their missions and modes of action. At the same time, a core set of organizational frameworks should be established that will give coherence and strength to the effort. The key principles are collaboration, openness and coherence.

In summary, key words that describe guiding principles for this international effort are:
- *bottom up - initiative, creativity concrete solutions*
- *top-down, sideways and diagonally - collaboration*
- *internationally - constructive pluralism within stable organizational frameworks*

COLLABORATION AND COHERENCE—WFME AND WHO

The core components of the framework emanating from the World Conference on Medical Education and the Edinburgh Declaration will be WFME working in close partnership with WHO. At the global level, the WFME office in Edinburgh will interact directly with WHO Geneva. At the regional and national levels, the main interaction will be through Regional and National Associations of WFME with the regional and national offices of WHO; the central offices of WFME and WHO will often be conduits for communication and involved in the interactions.

Thus, WFME, in close liaison with WHO will serve in a coordinating, guiding and catalytic role, maintaining a broad view of medical education internationally, co-ordinating implementation of the overall action plan expressed in the Edinburgh Declaration, promoting the development of arrangements to support change at regional, national and institutional levels, and co-ordinating the monitoring of such changes.

WFME and WHO, in their co-ordinating function, will invite and encourage participation from other interested parties. This is in appreciation of the strengths that lie in them, and also in recognition that WFME and WHO will not always have the strongest or most relevant experience and expertise for dealing with a particular situation or set of problems. This openness for collaboration will help to avoid duplication of existing efforts, and contribute to complementary actions so as to promote optimal use of available resources, interest and commitment. An important principle is to promote coherence of action through collaboration and not fragmentation through independent pluralism.

Coherence of action through collaboration: not fragmentation through independent pluralism.

THE NEXT STEPS

An International Collaborative Programme for Reorientation of Medical Education

In accordance with these principles, an International Collaborative Programme for Reorientation in Medical Education is being established. It will be referred to here as the Programme, and the steps to be taken toward its implementation are described below.

WFME, in concert with WHO, should undertake the following steps without delay:

At the Global Level

1. Ensure adequate financial support for the Programme.
2. Establish an appropriate and supportive institutional base in Edinburgh for the Programme.
3. Develop, in conjunction with WHO, a body (or bodies) to advise, oversee and support the functions of the Programme.
4. Develop further the collaborative relationships with other UN agencies, including UNESCO, UNICEF, UNDP, World Bank, and other bodies.
5. Explore the interests of international sponsoring bodies, including foundations and trusts.
6. Extend an invitation to other interested organizations, agencies, networks and individuals to explore the ways in which they could participate in this international collaborative effort.
7. Convene meetings of the Executive Committee of the WFME to further its understanding of its functions in the further development of the Programme.
8. Based on the emerging national and regional plans of action, develop and then implement a global plan of action for the Programme.
9. Develop and implement an operational plan for the central office of the WFME.

Extend an invitation to other interested organizations, agencies, networks and individuals to explore the ways in which they could participate in this international collaborative effort.

At the Regional Level

1. Disseminate information relating to the World Conference and the Edinburgh Declaration.
2. Facilitate and support ministerial meetings in each region.
3. Facilitate and encourage meetings with deans of medical schools, directors of health services and other appropriate parties.
4. Facilitate meetings with WHO, UNESCO and other appropriate international agencies.
5. Extend an invitation to other interested organizations, agencies, networks and individuals, including medical students and other health professionals, to indicate the ways in which they could participate in this international collaborative effort.
6. In close consultation with interested parties, formulate regional organizational frameworks for effectgive constructive involvement of all who wish to participate.
7. Review and up-date regional plans of action including: initiatives undertaken, countries and institutions involved, parties responsible and time frames.
8. Establish mechanisms for monitoring initiatives and reporting back to interested parties.
9. Explore interests and potential for inter-regional collaboration.
10. Seek financial support for Regional Programme.

In close consultation with interested parties, formulate regional organizational frameworks to make the best use of the constructive involvement of all who wish to participate in this effort.

At the National Level

1. Disseminate information relating to the World Conference and the Declaration of Edinburgh.
2. Facilitate and encourage meetings with deans of medical schools, directors of health services and other appropriate parties.
3. Extend an invitation to other interested organizations, agencies, networks and individuals, including medical students and other health professionals, to indicate the ways in which they could participate in this international collaborative effort.
4. In close consultation with interested parties, formulate national organizational frameworks for effective constructive involvement of all who wish to participate.
5. Review and up-date or initiate formulation of plans of action, including: initiatives to be undertaken, institutions involved, parties responsible, and time frames.
6. Establish mechanisms for monitoring initiatives and reporting back to interested parties.
7. Explore interests and potential for inter-country collaboration.
8. Seek financial support for National Programme.

At the Institutional Level

1. Disseminate information relating to the World Conference and the Edinburgh Declaration.
2. Facilitate and encourage meetings with deans, teaching staff and students of medical schools, and directors of health services and other appropriate parties.
3. Review and up-date or initiate formulation of plans of action, including: initiatives undertaken, institutions involved, parties responsible, and time frames.
4. In close consultation with interested parties, formulate institutional organizational framework for effective onstructive involvement of all who wish to participate.
5. Establish mechanisms for monitoring initiatives and reporting back to interested parties.
6. Explore interests and potential for inter-institutional collaboration.
7. Seek financial support for Institutional Programme.

THE LARGER TASK

With the closing of the World Conference on Medical Education, a critical chapter in the story of promoting global reorientation in medical education ended. But another chapter began. The four years of preparatory work at institutional, national, regional and global levels have now crystallized into fresh conceptual, organizational and programmatic forms that reflect an evolution from earlier forms.

The strategy of a step-wise process leading to Regional Meetings and the World Conference, now achieved, is being replaced by the International Collaborative Programme for Reorientation of Medical Education. The Planning Commission, which had guided the process over the four year period, will now give way to new forms of programmatic governance. Each Region will now further elaborate and implement its Regional Plan of Action. The financing of WFME and the various national and regional meetings will evolve into a Budget for the Programme.

WFME has a Constitution under which it has a mandate that is broader than the Programme now being formed. Accordingly, the organizational structures should take into account both the broad mandate of WFME and the specific entity of the Programme. The organizational frameworks at each level need to provide coherence among the several participating groups, while also allowing an openness that will encourage collaboration and minimize duplications.

The interactions among the large range of organizations and institutions, not all of which have yet been specified, will now find more concrete organizational form (see following diagram). At this time it is appropriate to indicate general relationships. More specific organizational frameworks and relationships will have to be worked out at each level.

Ahead remains the larger task—to move beyond concepts and plans for action to implementation, and therein to grapple with the actual steps of reform, to construct a global support system for institutions that are engaged in the change process, to link with them in an interactive way so that their daily problems direct practical response from the Programme.

Relevance between medical education and the needs of society is a crucial concept, for medicine fails where it does not best serve humanity. This Programme—to support the necessary reorientation of medical education—has the opportunity to strengthen the capacity of medicine worldwide to respond to this mandate. The prospects must be good, since those who have created the opportunity—leaders responsible for medical education from around the world—are also those who are ready to take the next steps of bringing their vision to reality.

AN ORGANIZATIONAL FRAMEWORK

WFME IN RELATION TO WHO AND OTHER PARTIES AT VARIOUS LEVELS