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EDITORIAL

Medical schools—do they add value?

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The global medical workforce currently poses complex issues around supply and demand, quality and safety, rapidly changing practises following explosions in knowledge with needs for new skills and significant impacts from information technology and an increasingly well-informed population. Traditional national borders are becoming highly permeable as a result of extensive physician migration and developments in E-Medicine. In the medical workforce the age of 'the global village' is well established.

The medical student pipeline is fundamental to keeping the complex adaptive system that is health services on track. In the current issue Boulet et al. argue that more should be known about the world's medical school collective and they provide a useful description based on currently available data. Those data show many mismatches nationally between supply and demand as well as a rapid increase in the number of medical schools globally. They are silent on quality.

Medical schools do more for a health system than simply supply the junior doctor pipeline. They play key roles in research, postgraduate training and setting practice standards. The content of medical courses world wide is largely the same with some variation in emphasis on particular disease patterns in different regions. It is the other activities of medical schools that really decide the quality of their graduates, e.g. mentoring, understanding of the role of research, role modelling, ethical lifelong professional development, communication and socialising skills and technical skills development.

The worldwide recognition that quality and safety in health services could be significantly improved poses a challenge for medical schools amongst others.

The implications of all of this are that medical schools need to play a well structured and preferably coordinated role in the global supply and quality of the medical workforce. Clinical academic medicine is currently going through changes that do not have a clear direction. Countries are struggling with registration of externally trained physicians.

Traditionally medical schools have each seen themselves as unique. They are, though not in the content of their program but, rather, in the staff–student interaction referred to above.

Is there a case, as suggested by Boulet et al., for better information regarding the quantity and quality of the medical workforce pipeline? In the face of the globalisation of physician migration, e-health and concerns about the quality and safety of health systems everywhere and the questions over the future structure of clinical academic medicine the answer surely is 'yes'. Individual governments will do their own thing about supply and accreditation. Is there a role for the global medical school collective to value add to such local action?

The publication of the article by Boulet et al. suggests that the Editorial Board of the journal sees this as a significant issue. Perhaps an influential group such as the Board could take up the issue on a global front. An argument can be raised that the medical education community is the only group that can advocate for this issue effectively and develop a proactive position. Not to do so could result in significant loss of influence by medical schools in the global development of supply and quality of the medical workforce.

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