What is the way forward in developing countries? Strengthening centres of learning and creating local capacity for conducting and overseeing appropriate research are critical for the promotion of academic medicine in developing countries.[10] Such measures and academic support for research must be coupled with easy electronic access and access to information. In a rapidly globalising world many health interventions and knowledge are truly global public goods and may provide solutions that are applicable to local needs. Recent initiatives such as providing electronic full text access to medical journals in developing countries are welcome and may be coupled with innovative projects such as the Ptolemy project, which links surgeons in Africa with information services at an academic centre in Canada.[w4] Such partnerships between institutions in the developed world and centres of learning in developing countries are important, but most sustainable initiatives for improving academic medicine and clinical research in developing countries must come from within.

Investments towards strengthening academic medicine and scholarship in developing countries are a necessity rather than a luxury. A strong correlation has also been shown between investments in science, health indicators, and economic growth of nations.[11] The Commission for Macroeconomics and Health has also recently made a strong case for increased global investments and partnerships in research as a means for stimulating economic growth and promotion of health.[12] The most durable and sustainable way to do this in developing countries is through strengthening academic medicine and the promotion of a culture of essential and relevant national research.

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BMJ Publishing Group to launch an international campaign to promote academic medicine

Please join us

Education and debate p 1041

Academic medicine is in crisis across the world.[1–4] Medicine's capacity to research, think, and teach is collapsing just at the time when science, social trends, and globalisation are offering great opportunities—and threats. The BMJ Publishing Group wants to help revitalise—and reinvent—academic medicine. How can academic medicine best prepare for the 21st century? We don't have an answer, but we propose a great debate.

We are not even entirely clear on the diagnosis. Why is academic medicine failing? The increasing pressure to provide service is one cause. Faced with healthcare reforms and government retrenchment, clinical research programmes and funding have withered. Lack of financial incentives and increasing disillusionment about the prospects of a career in academic medicine have hampered efforts to recruit and retain faculty. Financial pressure on universities means that the brightest and most imaginative scholars come second to the scientists who bring in large sums from industry. Lack of rewards for good teachers poses a serious threat to future medical education and research.

Collective action is needed, and the BMJ Publishing Group is keen to be a catalyst. Our board has given us £50 000 to start the process. We want to partner with individuals and organisations to create dialogue and debate about the best strategies to revitalise academic medicine. It seems clear that more of the same will not be enough for academic medicine.[1–5] It needs to change, and we should probably talk of academic health care not academic medicine. The campaign, international and collaborative in spirit, will, we hope, encourage more resources to flow into academic health care and promote reinvestment in scientific and teaching excellence.

The BMJ Publishing Group is in a good position to spark the campaign. We, like other publishers, depend on what academic medicine produces. Academic health professionals constitute a core readership. It's in our best interest to raise the profile of academic medicine both within the profession and internationally.

But we cannot possibly do this alone. We are busy forming links, but we need a leader, an international advisory board, and help from as many institutions, academics, and other journals as possible. Funding for the campaign may come from a range of private and public

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organisations including pharmaceutical companies themselves beneficiaries of academic medicine.

Please send us your suggestions and nominations for the leader of this international campaign to promote medicine.

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Competing interest: Both authors are employees of the BMJ Publishing Group. The group expects to spend money on this campaign not to make money, but the group would hope to benefit from a successful campaign.

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The management of acute mania

Encouraging results from clinical trials need to be replicated in practice

Bipolar disorder is a common, severe psychiatric disorder that is characterised by recurrent manic, mixed, and depressive episodes. Cognitive, behavioural, and psychotic symptoms often occur during mood episodes, and suicide rates in bipolar disorder are among the highest of all psychiatric illnesses.[1] Acute bipolar manic and mixed episodes often constitute medical emergencies, requiring admission to hospital to ensure safety and rapid recovery. However, morbidity from mania is not limited to acute episodes as full recovery of functioning often lags months behind remission of symptoms.[2] Medications form the cornerstone of treatment of mania, and in the past decade randomised controlled trials of new medications for this syndrome have proliferated. These studies have addressed important questions about the short term efficacy and tolerability of new agents, alone and in combination.

The efficacy of agents for the treatment of acute mania has typically been established in three to four week, placebo controlled, randomised, parallel group, monotherapy trials in patients admitted to hospital without clinically significant medical or psychiatric comorbidity who are able to give informed consent. These trials provide important data about the ability of an agent to reduce manic symptoms over a minimal time period sufficient to measure improvement. Lithium, valproate, carbamazepine, and the atypical antipsychotics, olanzapine, risperidone, quetiapine, ziprasidone, and aripiprazole have established efficacy compared with placebo in at least two such trials.[3 4] This body of evidence represents a substantial expansion of the therapeutic options available for the treatment of acute mania. This is good news for patients and clinicians alike.

But what exactly do these studies tell us? Lithium and valproate in the United States, and lithium and carbamazepine in Europe, have been first line treatments for acute mania for many years.[5] Interestingly, the first placebo controlled, parallel group trials showing carbamazepine's efficacy in acute mania have been completed only recently. Typical antipsychotics also have been widely used for acute mania for decades, but in the absence of any efficacy data from placebo controlled trials except for one small study of chlorpromazine.[6] The recently shown efficacy of atypical antipsychotics in acute mania represents a real advance in treatment. Beyond the overall efficacy data themselves reported in these studies, the atypical antipsychotics have the advantages of improved tolerability over typical agents and relatively rapid rates of onset, with evidence of significant reduction of manic symptoms within 2-7 days compared to placebo.[7]

However, limitations to translating these efficacy data to effectiveness in clinical practice are notable.[8] Exclusion of severely ill patients who cannot provide informed consent, limitations imposed on comorbidity by exclusion criteria, and high dropout rates restrict the generalisability of study results.[8] In most studies, response rates (usually defined as those patients displaying a 50% or greater reduction in manic symptoms from baseline to end point) range from 40-65%, with differences in response rates for drug and placebo ranging from 20% to 40%. In clinical terms, this means that in positive studies, some 50% of patients have at least 50% improvement.[9] The glass is half full, or half empty. The goal of treatment in practice is remission of symptoms and restoration of functioning. These trials were generally not designed to assess these critical outcome measures.

It may be too much to expect a single agent, at least among those presently available, to produce rapid and complete symptomatic remission for most patients within relatively brief time frames of 3-4 weeks. This brings us to the use of combination treatment for acute mania. Although giving antipsychotics in combination with lithium, valproate, or carbamazepine in hospitalised manic patients has been common practice in the United States, and to a lesser extent, in Europe, since the 1970s, the superior efficacy of such combinations was shown only recently in clinical trials of adequate power.[10] Nevertheless, combinations of valproate and typical antipsychotics, and of the atypical antipsychotics risperidone, olanzapine, and quetiapine with lithium, valproate, or carbamazepine had greater and more rapid response rates than placebo plus monotherapy comparison groups. Notably, combination treatment was generally well tolerated in these trials. As a group, these studies imply that combination treatment for most patients in hospital for mania represents a substantial acute advantage in treatment over monotherapy.

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