

those global responsibilities. Does academic medicine care?

Jocelyn Clark *assistant editor and project manager, academic medicine campaign*

BMJ, London WC1H 9JR
(jclark@bmj.com)

Peter Tugwell *professor of medicine and leader of the campaign*

Institute of Population Health, University of Ottawa, Ottawa, ON, Canada K1N 6N5
(elacasse@uottawa.ca)

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Academic medicine and global health responsibilities

Academic medicine can contribute in four ways

The launch of the campaign by the *BMJ* and a range of partners to revitalize academic medicine¹ is extremely welcome at this time when the effects of globalisation on health (and vice versa) are being felt more than ever. In my seven years as dean of the progressive Makerere University Medical School I have seen the faculty become increasingly disillusioned about the prospects of a career in medicine. National and global pressures have reduced available resources considerably, making it much harder for the medical school to support the different pillars of academic medicine. We must champion excellent scholarship in academic medicine—the discovery of knowledge, the practice of teaching, and the integration and application of knowledge²—while ensuring that the needs and interests of Uganda's communities are adequately served.

Academic medicine must show that, in its pursuit of the different aspects of scholarship, its relevance to society's needs is still of paramount importance. This is vital if academic medicine is to continue to influence global health and, moreover, if it is to retain the sympathy and support of its partners. The number of partners influencing academic medicine—particularly in less developed countries—now includes national and regional governments, multilateral development agencies, non-profit private organisations, foundations, development banks, development assistance agencies, professional bodies, public and private academic institutions, pharmaceutical manufacturers, and other private sector companies, and consulting agencies.³

In which areas can academic medicine contribute to global health? Firstly, by conducting relevant research. Global health is crying out for high quality research that will answer many important and perplexing questions. Important aspects of the illnesses that ravage Africa, such as AIDS, tuberculosis, malaria, and

other communicable diseases, as well as the challenges of drug resistance and service delivery, still baffle humankind.

Secondly, by implementing evidence. Rather than stop at producing research results and a publication in a scientific journal, academics must endeavour to close the “research to action/policy” gap. This requires energised joint efforts between academic researchers and policy makers or practitioners. Otherwise the benefits accruing from research efforts are not fully utilised if research has no impact on the health of global populations.

Thirdly, by rethinking health human resources. Vasant Narasimhan and colleagues of the Joint Learning Initiative have emphasised the growing crisis of inadequate health workers to support health systems, especially in the developing world.⁴ Academic medicine needs to rethink how best to provide adequate pre-service and in-service training of health workers. Prominence needs to be given to what type of health workers are trained, the conditions of the training environment, the numbers trained, and the skills and competencies imparted. Academic medicine clearly needs to undertake a thorough review and reorientation of the educational process to improve the human resource situation and its performance in the health system.

Moreover the global human resource crisis continues to be vexed by “brain drain” issues.⁵ Academic medicine may have a destructive role in global health by attracting and recruiting well trained personnel from the South. The reverse should be strongly advocated and encouraged. Northern institutions of academic medicine must actively promote and support building capacity for academic medicine in the South so that Southern institutions can play a meaningful role in global health. This may be achieved through innovative training programmes both at home and abroad.⁵ In addition the North should send some of

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their faculty for varying periods of time to work with their counterparts in developing countries and through collaborative projects. Developing conducive incentive structures will be crucial to this goal.

Fourthly, by enhancing the quality of service delivery. Academic medicine has embraced evidence based medicine as a means of improving the quality of service delivery, but this approach has not percolated down to other health service providers. Efforts on the part of academic medicine to influence others in the healthcare industry to use this approach would be beneficial. Globally, academic medical personnel have resented the increasing requirement to spend more hours in patient care—expected to increase as the burden of illness mounts in the South—which leaves little time for other scholarly activities. Reasonable compromises need to be developed, and these will be specific to institutions and environments.

Furthermore, a major bottleneck to improving health service delivery is a lack of access to quality health information. We need leadership within academic medicine to promote access and use of information communication technologies addressing global health issues.

Global health has brought to prominence issues of inequity with respect to many health issues such as AIDS. Activists have played a major role in highlighting inequity; academic medicine has not, but should.

A career in academic medicine is increasingly subject to more accountability from our clients, whose expectations are on the rise, yet the resources to deliver continue to decline. Attracting newcomers to the field is more and more difficult. We all have a duty to overcome the obstacles and make academic medicine more exciting and rewarding.

Nelson Sewankambo *dean*

Makerere University Medical School, Makerere, Uganda
(sewankam@infocom.co.ug)

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Academic medicine as a resource for global health: the case of Brazil

Improving population health demands stronger academic input

The world has witnessed enormous changes in population health in recent years. The main sources of disease burden are now non-communicable diseases, and death and injury from external causes such as accidents, homicide, and suicide.¹ This shift has demanded entirely new organisational structures and expertise within the health sector at a time of great increase in technology and, consequently, in health costs. These changes have been especially difficult to assimilate in developing countries, which must also continue to deal with a large burden of communicable diseases such as AIDS. To overcome these challenges, the *World Health Report 2003* recommends strengthening health systems by centring action on primary health care and by integrating health promotion and disease prevention across all levels of care on behalf of the entire population.²

The campaign to revitalise academic medicine offers an excellent opportunity to question how academics can respond to these challenges.³⁻⁴ The case of Brazil, a large middle income country with marked social inequalities striving to improve population health, provides an example.

Until the 1980s public health, medical care, and education in Brazil were pieces of a fragmented whole. Publicly financed health care was limited to unevenly supported emergency room and hospital treatment, coupled with a primary care system dedicated almost exclusively to management of infectious diseases and to maternal and child care. Public health agencies

focused their activities on infectious diseases, especially vaccine preventable and endemic parasitic diseases. Medical education was almost exclusively performed within university hospitals oriented towards tertiary care. The implicit goal of most students was to become, like their academic mentors, a specialised “private physician.” The interface between training in clinical medicine and public health would be better described as a gap.

Over the past two decades, much has changed. Publicly financed health care has been unified and reformed extensively. The national health system (Sistema Único de Saúde, SUS) now covers more than 70% of the population and strives for complete medical coverage, at all levels, providing care for chronic illnesses and high technology procedures such as transplantation. A family medicine model of primary care has been adopted, based on multiprofessional health teams led by doctors and nurses, serving registered, geographically delimited populations.⁵ Each team includes several salaried members of the community. This new model is expanding rapidly and now, in its eleventh year, provides coverage for almost 40% of the population.⁶ Public health activities such as disease surveillance, health promotion, and community based prevention have expanded and now include recognition of chronic diseases, injuries, and accidents.

Academic medicine has also changed in Brazil. Clinical epidemiology, central to evidence based medicine and vital to creating the bridge between clinical medicine and public health, has been introduced into