

RESPONSE TO THE FOUR QUESTIONS

The nature of the problem with academic medicine

Academic medicine is not performing optimally. It has an honorable history which is both its source of strength and an encumbrance, but this is not enough to depend on for the future.

Academic medicine is still seen to be the means of educating future doctors and advancing some areas of practice, especially surgery. This is necessary but unexciting stuff, especially when medical imperatives and prejudices are considered by those who pay for health care to be part of the problem, rather than the solution. Academic medicine has become institutionally rigid with its persistent attachment to organizational arrangements that are out of date, its clinical practitioners overworked in the belief that one can provide first class clinical care and be a first rate research worker, and unable to come to terms with advances in educational understanding and knowledge which it often dismissed with derision. It is baffled as to its place in relation to genome science, commercial interest in research and the behavior and expectations of society informed by the web. It has a choice: behave like the Roman Empire in its last days, or recover a connection with science which advances when its practitioners taking competitive advantage of mistaken ideas and move on from them incrementally and persistently or by leaping over them.

Academic medicine will need to work out what it wants to do in a world where technology advances and geographic boundaries dissolve. It needs a message in response to global health challenges whether they are posed by HIV/AIDS or escalating chronic disease burdens in ageing third world nations.

What could be done?

The aim would be to stimulate discussion and decisions that would lead to a renewal of academic medicine, with a fresh vision, interested and enthusiastic participants and additional resources, aimed at enabling academic medicine to contribute more to the improvement of global health.

An approach to the problem as proposed by the BMJ could make great use of the Journal's capability and status. It could use its print and web-based capacities to provoke debate. A 'new Flexner' view of the future should be goal, and it should be formulated in such a way that it is convincing to those who can finance academic medicine. This new view would need to include a deep exploration of how academic medicine could come to function in low- and middle-income countries in a way that is fully responsive to their health needs, rather than preparing a cadre of practitioners who meet the needs of wealthy elites or who are prepared as a form of export action for practice in wealthy countries.

To oversee the work of the BMJ taskforce, an overseeing board would be established. This should be representative of those who have an intense interest in academic medicine, and a balance would need to be worked out so that it did not become parliamentary in

style but which would enable the taskforce to have global reach but with strong connections to the major institutions of academic medicine as it is.

How might we go about it?

The board could then convene a meeting of senior academic medicine practitioners, say at the Rockefeller Center in Bellagio (assuming the Rockefeller Foundation could be recruited which I believe it could given its long interest in health professional education and its recent commitment to exploring health workforce development as a global matter), to start a process of critical review and strategic planning. A series of working papers would be commissioned prior to that meeting covering areas that include academic medicine and medical academics in civil society, medical education reform, research organization, the interface with commerce and industry in research, the future of clinical research and its nature, career structures in academic medicine, relation to funding agencies both public and private, academic medicine's responses to global health challenges, north-south partnerships in academic medicine development and so on.

Each of these working papers and the Bellagio responses would be posted to the BMJ website for open discussion. A communication strategy would be formulated to deal with the outcomes of the meeting.

While some might well argue that, from the outset, other health professions should be involved in this discussion, my view is that there is a great need for medicine to get its act together first and then from a position of clarity engage in conversation with other health professions.

This process of critical appraisal and vision building might well take the best part of a year. Part of the commission to those writing papers and to the Bellagio meeting would be to specify what action they consider should be taken to advance academic medicine's contribution to society, and an estimate of what is needed for that to occur.

New approaches to the practice of academic medicine should emerge from this process. These then should be able to be put to the test and it is here that additional resources might be sought, whether the new idea be in relation to education, research or service. Groups such as the Nuffield Foundation, the Rockefeller Foundation, and the Bill and Melinda Gates Foundation should then be approaches for support. This is most likely to come if a new congruence emerges between academic medicine and global health needs. For example, a proposal from academic medicine as to how it could contribute to the development of a workforce capable of assisting with primary care-based administration of anti-retroviral agents in Africa would presumably be of interest to Gates, WHO and others.

My contribution

In the accompanying letter I describe my career to date and my strong commitment to academic medical development and reform over the past 25 years. I have spanned clinical medicine and public health in my research and have worked extensively in health policy development. I am familiar with the politics of new and old universities and

medical schools and have served as a senior manager in the University of Sydney for six years. I have an intense interest in global health issues. I have the capacity to envision and to lead, and I have a good track record of encouraging and supporting younger colleagues. I believe I could make a substantial contribution to the process as proposed.

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