

# Open letter to the leaders of academic medicine

As their campaign comes to a close, **ICRAM** presents a challenge to academic medicine's invisible leaders

We are not sure who you are. Unsubstantiated rumours suggest that you may not exist at all. We wonder where academic medicine is getting its lead from. Is it some of the many serious scientists, clinicians, and educators? Is it people with illnesses, those who wish to remain healthy, or society at large? Is it political leaders of uncompromising principles and vision? Is it selfless benefactors and visionary entrepreneurs? Or is it self interested compromisers carrying embellished titles acquired through anything but merit? Maybe it's corporate industry escorting academic medicine to the dance tonight?

You might ask who we are. We are participants in the International Campaign to Revitalise Academic Medicine, a group of mostly young academics from around the world who feel that academic medicine needs reinvention (box). We have gathered evidence systematically, consulted and debated globally, and given thought to how the future might look. Here is what we think.

## An academic dys-ease

Academic medicine entails critical thinking, research, innovation, teaching, learning, and leadership in improving health care. If this really is the job description, then few human activities are more essential for the future of humankind. So why does the mere term "academic medicine" bring to many people a feeling of long standing malaise? This malaise reflects an absence of a compelling vision for the future, difficulties in both recruiting and retaining the best and the brightest, debasement of values, disconnection from stakeholders, and lack of a global outlook.

The pursuit of health is a global priority. Health care consumes an ever increasing proportion of gross national products. However, even in the countries that devote the largest resources to health, provision is beset with the serious problems of poor quality, danger, limited access, poor usability and responsive-

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ness, low productivity, and lack of affordability.

While life expectancy continues to increase in the rich world, it is shrinking in much of the poor world. Furthermore, most of what we would like to know we don't know—for example, how to cure advanced cancers, the common cold, and many degenerative diseases or how to deal with emerging diseases. Challenges to academic medicine are momentous, coming at a time when science—particularly genomics and information technology—is taking great leaps forward. Are we meeting these challenges?

## What is your vision?

Assuming that you do exist and that you have the ethos and, yes, the power to change things, we ask with respect and curiosity, what is your vision? We've repeatedly heard the standard promotions for academic centres: "We do the best research, we offer the best care, we are the best teachers, our discoveries shake the world, we save lives, we create medical superstars . . ." Please, can we send the public relations people for a break and try to agree. How much can be achieved? What are our priorities?

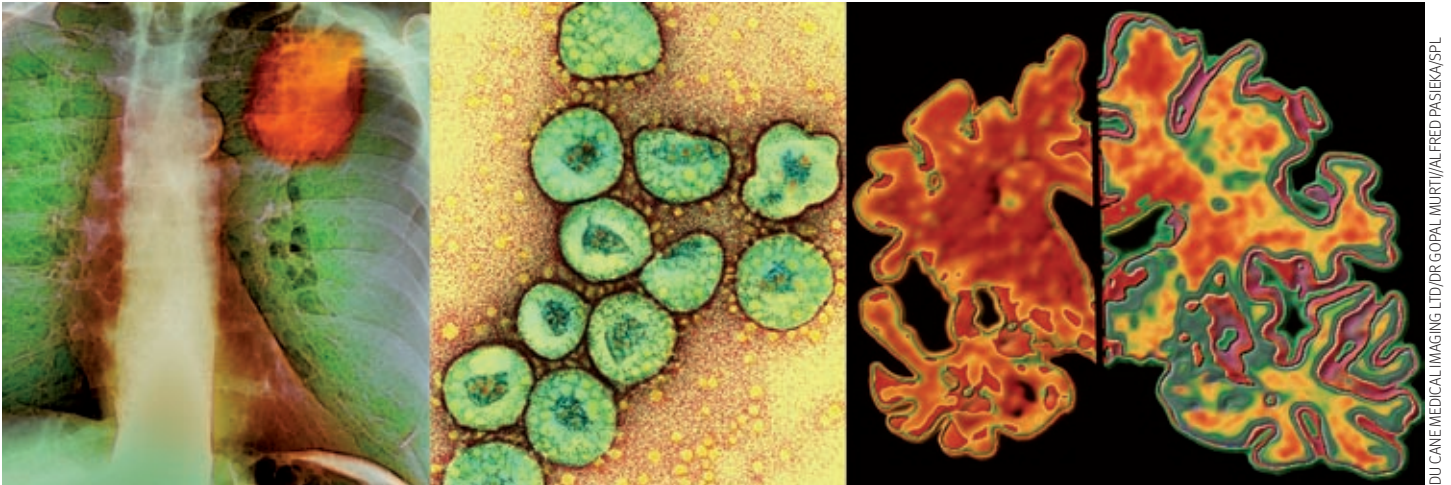
Some medical schools have chosen to concentrate on research—and in some places publicity, honours, and resources tend to follow research achievements. Yet even such "top medical schools" have to make choices. For example, basic science research is quite different from the critical evaluation of new or untested treatments and practices. Basic research and public health are often growing as isolated from each other as the pre-Colombian civilisations were from their contemporaries in China. Who is going to translate these pictographs into languages that others can understand—let alone make use of them?

Innovation often comes from mixing people of different backgrounds—perhaps basic and social scientists—and may mean innovation in methods of learning. Institutions that concentrate on research may do less well at teaching. Teaching, learning, and thinking are not equivalent terms. Moreover, some aspects of the function of academic institutions may have more to do with business than with science, teaching, learning, or thinking. At the end of the day, do we pursue health or wealth? We may find a focus that maximises both, but sometimes they will pull in opposite directions.

Provided that you have a vision and that you are not some kleptocratic rogue appointed by a dictator at the Ministry of Health, you need to decide what you want. One kind of vision is, "We will be the world's leading medical institution, bringing in more research income

## What is ICRAM?

The International Campaign to Revitalise Academic Medicine (ICRAM) was launched in 2003 by the *BMJ* and 40 other partners concerned about a decline of academic medicine globally. A working party of 20 mostly young academics was created under the leadership of Peter Tugwell in the summer of 2004 to foster debate on the future of academic medicine worldwide. Readers will find additional information about ICRAM's efforts in our collected resource at [bmj.com/academicmedicine](http://bmj.com/academicmedicine).



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### Cancers, colds, and degenerative diseases: will academic medicine find a cure?

and winning more Nobel prizes than any other.” However, few institutions can compete for such a vision. Most institutions must create something more imaginative. For example, “We will create an institution that trains our students to be prepared to improve health-care systems and adapt rapidly to change,” or “We will train the leading proponents of improved global health, working to reverse the inverse care law—in both the local and global arenas.”

#### Best and brightest

A compelling vision requires the right people to materialise it. We don’t want to see academic medicine replete with stagnation, compromise, pettiness, opportunism, selfishness, monolithic dogma, and intellectual narcolepsy. We don’t want academia to provide authenticity to rotten societies with debased, non-humane values.

We need to attract truly the best and the brightest with respect to the skills that will advance medical science and global health. These individuals are not simply those students with the highest IQs and examination scores. We need people with fitness for purpose and undeterred commitment. If the mission of a medical school is, for example, to produce health workers to work in neglected rural areas then it needs staff and students with resilience, independence, a love of rural

#### Priorities for academic leaders

- Think carefully, boldly, and imaginatively about the vision of your academic institution
- Ensure that the vision is based on values, and stay true to those values in everything you do
- Recruit students and staff that are fit for the purpose, and create a climate that values diversity and work-life balance
- Accept responsibility for the poor public image of academic medicine, and work hard to interact with all stakeholders
- Always take a global outlook, and create partnerships that aim to redress the rich-poor gap

areas and their peoples, perhaps some contempt for urban pleasures, and an ability to improvise.

Financial incentives are important to attract, motivate, and reward students and staff, but they are not sufficient—at most institutions worldwide they are simply not available. We need a climate that values diversity and where success does not destroy work-life balance. We seek excitement and inspiration, a sense that this adventure is about being part of something very special.

You might think this impossible, but we’ve seen it done with organisations like the Cochrane Collaboration and the International Clinical Epidemiology Network—where some of the cleverest people we know from around the globe have volunteered their time and efforts to advance the integration of medical knowledge and its application to population health.

#### Promote and live by your values

The smallest gap between rhetoric and reality rapidly undermines any institution. Too many institutions have damaged themselves by becoming strangled by business. It is by no means wrong to interact with the private sector (and some institutions might make this their primary focus), but a successful institution should be clear about its values, live by them, and never debase them in the pursuit of short term gain. Not every institution will have the same values, but some values seem fundamental to all. Perhaps the most basic might be the pursuit of truth, wherever it might lead, and the genuine interest to help people and our communities.

#### Interacting with stakeholders

Many of the public find it hard to articulate the value of academic institutions. Too many politicians view academics as a powerless nuisance, intellectuals of no consequence—except when temporary circumstances require a touch of “health, research, and education” mustard in their bleak rhetoric.

Many healthcare practitioners, struggling at the clinical coalface, consider academics to be unreachable

narcissists. Many students are made to feel foreigners in their own universities. Business may see medical schools as a cheap place to buy respectability rather than as true partners.

Communities around medical schools are rarely closely related to them. Patients feel more like experimental subjects. Political, religious, and corporate dogmas cumulatively undermine both academic and community freedom around the world. The malaise that affects academic medicine has much to do with losing healthy contact with stakeholders.

In some languages academic has become synonymous with something so remote that most people would not have any interest in it. Enhanced interaction is likely to benefit all, especially when guided by transparency, meritocracy, respect for both individual talents and teamwork, and pursuit of the common good. In our future scenarios we envisioned medical academics becoming much more central to public life—offering an uncompromising and honest debate to politicians and policy makers, being useful to and teaming up with practitioners, enabling students and learning from them, interacting creatively with truly innovative business, empowering and being empowered by democratic and meritocratic communities, and involving patients as teachers and “co-learners.” A healthy societal environment that cherishes and promotes both freedom of thought and action and team communication is crucial for this endeavour to succeed.

### A global outlook

The shocking—and growing—gap between the world’s rich and the world’s poor must not continue. We imagined a future where academic medicine takes the lead

**A healthy societal environment that cherishes and promotes both freedom of thought and action and team communication is crucial**

in closing this gap. In the future we have imagined medical schools from the rich world partnering with schools from the poor world. The brain drain reverses and mutual benefit accrues. Academic practitioners become the spokespeople for the future generations, using evidence to explicate the long term effects of climate change and global degradation. We imagined a future that inspires the truly best and brightest, inevitably a global future.

### Conclusion

Complacency can destroy any institution—academic or otherwise. We live in a world full of both opportunity and threat, but where change is unavoidable. Academic medicine has not met the challenges effectively.

Dear potential leader of academic medicine, we don’t know whether you exist, but we sincerely hope you do. You may be a dean, a faculty member, a practitioner, a politician, a businessman, a student, a patient, a citizen—any or many of the above. You can be a true leader regardless of your formal title or lack thereof. We have no doubt that you will succeed if you invest in an uncompromising yet positive vision. We hope that you find at least some of our ideas useful, and we wish you luck in building a healthy and creative future for us all.

**Contributors and sources:** RS wrote the first draft, which was heavily criticised. JJ wrote the second draft in the light of comments received from all the contributors. After a further round of comments JJ and JC produced the final draft, which everybody has read and approved. JC has assembled the collected resources. JJ is the guarantor.

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- 1 Clark J. International Campaign to Revitalise Academic Medicine. Five futures for academic medicine: the ICRAM scenarios. *BMJ* 2005;331:101-4.

## A model patient

Mary wasn’t feeling very well according to the nurse on the other end of the telephone. The nurse said that Mary “came over a bit funny” at the dinner table and was found to have an irregular pulse with a rate of about 30 beats/minute—enough to make anyone come over a bit funny. I went to see Mary, examined her, and performed electrocardiography, which confirmed slow atrial fibrillation.

I contacted the cardiology registrar, who listened patiently while I presented my case. At the end of my monologue, she immediately agreed to review Mary with a view to putting her on Friday’s list for a pacemaker.

I have to confess, I was shocked. Why? Because Mary is 89 years old and has Alzheimer’s disease. She is otherwise well, apart from well controlled hypertension, but on previous occasions when we have referred our patients with dementia to other specialties we have often met with resistance.

The stigma of their condition means that it is often assumed that non-psychiatric wards won’t be able to handle their behaviour or that their current quality of life is so poor that prolonging their life isn’t a worthwhile use of resources. But today was different; today Mary was treated like any other patient in need of interventional treatment.

The screening blood tests were done (they were better than

mine), and Friday came. I telephoned the cardiology ward to explain how best to handle Mary and to ask them to call me before her procedure if they wanted me to accompany her.

The telephone didn’t ring. The whole ward waited for news. Eventually, by lunchtime, we couldn’t bear the suspense any longer, and we phoned the ward to ask how she was.

The sister told me how wonderful Mary had been, the only one on the list who didn’t need sedation. It seems that Mary had been the model patient—keeping her arm still, not meddling with her cannula, and keeping the department amused with stories of her mischievous youth.

Mary made an uneventful recovery and now has a new lease of life; in fact she’s got more energy than I have on some days.

We are fighting the stigma of mental illness on a daily basis, not just in public but also within the medical profession itself. I am delighted to see that the tide is turning in favour of improving the management of patients with dementia. Mary is living proof that it is worth judging each patient on a case by case basis and not by diagnosis or age.

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