Commentaries

Commentary: The agenda for academic excellence in “global” surgery

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We have reached a critical juncture in academic surgery. Largely ignored for decades, the magnitude and impact of the global burden of surgical disease, which makes up 11% of disability-adjusted life years worldwide,1 is drawing increasing attention; scores of young and aspiring surgeons are now truly interested in global health work. While previous literature has examined the barriers to accessing surgical care in resource-poor environments from the perspective of patients,2 Calland explores the corresponding structural, financial, and sociocultural barriers to providing such care from the perspective of U.S. academic surgeons (ie, academe). At the same time, this paper serves as a call to action for the academic surgical community to accept and nurture what many view as the new field of global surgery.

In the past, most of the world’s “bottom billion” have received no surgical care at all, with one notable exception being when the rich world’s attention is drawn suddenly to “natural” disasters in the poor world. In the immediate days after the January 2010 earthquake in Haiti, Port-au-Prince and environs was probably home to more surgeons per square mile than London, New York, or Tokyo. A first step involves shifting global surgery from a vertical model of disaster response toward building systems of surgical care—this means, perhaps above all, training surgical teams in places that need them most. Academic partnerships can help improve access to and quality of care, decrease the disparities in access to surgical care, and strengthen health systems.3 The academic surgeon must have a place in global health.

The extent to which academe embraces this concept will depend on whether academic global surgery becomes a viable career path, not merely a “side project” that a selected few pursue in their free time. Departments of Global Health at medical schools and teaching hospitals must open their doors—and their tenure-track jobs—to surgeons and anesthesiologists, as must all public and private institutions engaged in global health research, training, policy, and delivery. This initiative will require new resources. Surgery departments tend to be smaller than their medicine counterparts. The hospitals in which we work are a telling example: Brigham and Women’s Hospital has a department of medicine of 824 faculty and a surgery department of 163 faculty; Boston Children’s Hospital has a department of medicine of 792 faculty and a surgery department of 35 faculty. The disparity is even more striking in subspecialty divisions: the temporary absence of one U.S. academic surgeon from a division of 4 represents 25% of that division’s revenue potential. The size of the funding gap will likely demand philanthropic fundraising mandates by hospital leadership.

But we need other kinds of resources, too. Even cursory analyses of the global burden of surgical disease underscore how great the need; to address such a burden will also demand skilled management. “To improve global health, what we need isn’t just Bill Gates’ billions, but Microsoft’s managers,” notes Josh Ruxin. “We need less do-goodism, and more do-it-rightism.”4 In the current setting of scarcity, often the academic global surgeon must be trained for both the operating room and the boardroom, wielding scalpel and spreadsheet with equal facility. With this goal in mind, Boston Children’s
Hospital launched a Global Surgery Fellowship in 2009 to furnish future surgical leaders with the academic, clinical, and administrative skills of global surgery, public health, and surgical systems development. Endowed fellowship positions—both clinical and research-based—combined with master’s programs in public health or business administration will allow a really new generation of surgeons and anesthesiologists to gain the skillset of an academic global surgeon. Through the Program in Global Surgery and Social Change, Harvard Medical School has embraced increasingly an academic platform and viable career pathway for surgeons and anesthesiologists interested in global health; academic promotion is based on global activities in health leadership, education, and research, not just publications.

While seeking to create a home for global surgery in the academy, we must never lose sight of our mission: to bring quality surgical services to the poorest people on the planet. Achieving that mission will require more than tacit acceptance of surgeons and their professional association; it must be embedded in the vision, strategic priorities, and budgets of academic institutions and teaching hospitals in the United States. Calland ends his paper with a question: Might this be the time to dovetail academic surgery and the emerging field of global health equity? The surge in interest in global surgery and above all the burden of surgical disease among the world’s poor and otherwise marginalized demands an answer to that question, and the answer must be an unequivocal yes.

REFERENCES

Commentary: An academic track in global surgery

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We laud Forrest Calland for his timely call to develop an academic track in global surgery. Heretofore, “academic global surgery” has been at worst an oxymoron and at best a cottage industry. Indeed, opportunities and challenges exist currently for such a track. We have witnessed a tsunami of interest from medical students, residency applicants, current residents, and even staff surgeons over the past decade. How to capture this enthusiasm, channel it effectively, and pay for it presents a continual challenge. Perhaps now is the time. Given the coupling of opportunity and interest, is there an economically viable place for an academic track in surgery? Will grants or even philanthropy help finance the program, as is the case for infectious disease or maternal and child health? Might there be research with publishable results that will meet the expectations of promotions committees for academic advancement? If one focuses solely on the challenges, little will be accomplished.

A foundation exists, but much more can be done to concretize a “track.” Individuals melding global surgery with their academic careers include such surgeons as Robert Riviello at the Brigham and Women’s, Georges Azzie at the University of Toronto, Stephen Bickler of the University of California, San Diego, Diana Farmer of the University of California, San Francisco, Dorek Ozgediz of University at Buffalo, The State University of New York, Serene Perkins of Oregon, Erik Hansen of Vanderbilt, Don Meier of Texas Tech, Fiemu

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