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
1. In December 2005, the World Health Organization (WHO) created and funded the Global Initiative for Emergency and Essential Surgical Care (GIEESC) to address the disparities in access to appropriate surgical care (http://www.who.int/surgery/globalinitiative/en/). Meena Cheran directs this ongoing effort. Charles Mock, a surgeon at the University of Washington, was seconded to the WHO for several years to direct the trauma aspect of this program and did so most productively. In addition, the Health InterNetwork Access to Research Initiative program, set up by the WHO in cooperation with major publishers, enables developing countries to gain electronic access to one of the world’s largest collections of biomedical and health literature (http://www.who.int/hinari/en/).

2. The American College of Surgeons established Operation Giving Back (OGB) in 2004 with Kathleen Casey as director. OGB maintains a database of stateside and international opportunities for volunteerism for surgeons, residents, and students seeking to address surgical and educational needs (http://www.operationgivingback.facs.org/).

3. The Global Burden of Surgical Disease Working Group, renamed the Alliance of Surgery and Anesthesia Presence Today (ASAP Today), was launched in Seattle in April 2008. There have been annual meetings since with support from Operation Smile, the American College of Surgeons, the International Society of Surgery, and many universities (the University of Washington, Vanderbilt, and the University of California, San Diego). This year’s meeting in Melbourne, Australia, held September 27–28, will be hosted by the Royal Australasian College of Surgeons (http://asaptoday.org/blog/). ASAP Today seeks to address global disparities in safe anesthesia and surgery and promote surgery as realistic public health. This inclusive group headed by Kelly McQueen serves as a catalyst and support group for those seeking to integrate global surgery and anesthesia into their careers, whether academic or community practice. John Hunter, Chair of Surgery at Oregon and editor of the World Journal of Surgery, has been most supportive of ASAP Today and in abetting the academic careers of surgeons devoted to global surgery.

4. The Pan-African Academy of Christian Surgeons (PAACS) is a nongovernmental organization in cooperation with the West African Colleges of Surgery (WACS) and the College of Surgeons of Eastern, Central, and Southern Africa (COSECSA) that is dedicated to the training of national surgeons “in country” at the district hospital level for retention and sustainability (http://www.paacs.net/).

5. The International Society of Surgeons has informed and energized many in academic surgery to consider how they might engage in addressing pressing needs globally in a sustainable manner via presentations at the ACS Clinical Congress sessions and at their every other year meetings. A focus of the President, Michael Sarr, at the 2009 International Surgery Week meeting in Adelaide was “Global surgical outreach—Partnering for sustainable solutions.”

6. Organizations such as the Association of Academic Surgery (AAS), the Society of American Gastrointestinal and Endoscopic Surgeons, and trauma societies have created educational, skills, and research programs for national meetings in sub-Saharan Africa. Skills centers have been set up in Ghana and Nigeria and other locations to transfer knowledge and technology to low and middle income countries, which are both resource- and technology-challenged. Fiemu Nwariaku, in his presidential address to the AAS in 2008, asked: “Where to go from here?” The Global Health Education Consortium includes teaching modules on surgical issues including noncommunicable diseases and injuries.

7. Academic Medicine dedicated the February 2008 issue to academic partnerships and twinning.

8. Conferences organized to educate and network abound. Brigham and Women’s University hosted a “Disparities in surgical care—Research to practice” in October of 2008 under the direction of Selwyn O. Rogers, Jr. A 2010 meeting in Boston entitled “The role of surgery in global health—Addressing the crisis—Anesthesia, surgical need and global health dialogue” brought together thought and action leaders. The Harvard Humanitarian Initiative, the Global Surgical Consortium, and other groups are active. The Center for Global Surgery of the University of Utah in Salt Lake City recently sponsored “Extreme affordability: Innovative solutions for surgical care.”

9. Canadians and Europeans are also quite active. The Ptolemy Project (http://www.ptolemy.ca/) provides literature resources via broadband, and surgeons at the University of Toronto have incorporated distance skills training via Skype in collaboration with the College of Surgeons of East, Central, and Southern Africa. The United Kingdom’s Teaching Aids at Low Cost (TALC; http://www.talcuk.org/) includes surgery and anesthesia in their offerings.
10. The Accreditation Council for Graduate Medical Education Surgical Residency Review Committee, in cooperation with the American Board of Surgery, released guidelines in April 2011 for approved general surgery rotations.

The major medical—and specifically surgical—challenge in sub-Saharan Africa is the inadequate workforce. With 25% of the global burden of disease, this region has only 2–3% of the global medical workforce to address this burden. In my opinion, the 5 great “surgical” challenges are as follows:

1. Safe airway and anesthesia management
2. Trauma (ie, trauma, trauma, trauma): Prevention, long bone fractures, osteomyelitis, spine and head trauma, and burns
3. Antenatal and perinatal care; women’s health issues
4. Cancer
5. Analgesia—Perioperative pain management; palliative care

These are areas that we as academic or community surgeons can address intentionally.

Individual surgeons have several choices about how they might engage a vocation or avocation in global health:

1. Live there: Government versus a nongovernmental organization
2. Visit there annually: Many places versus 1 place regularly
3. “Hold the ropes”: Be an informed activist

4. Be part of or support an organization’s effort at education, skills transfer, etc (eg, AAS, SAGES, or PAACS)

For low and middle countries, the local surgeons and physicians should dictate, direct, and deliver the care for their people; therefore, their priorities are paramount. We have an opportunity to help, advise, and support their efforts and perhaps enable improvements in the timely delivery of basic care. Although we cannot “fix” their problems, we do have the opportunity to partner with our colleagues as we seek to address disparities and improve access and care broadly and globally. We must, however, focus on sustainability.

Dr Calland has highlighted the current climate, the threats to academic development, disincentives to academic and clinical departments, and disincentives to the individual surgeon, including educational indebtedness, but also the rewarding opportunities. Noting that “all politics is local,” there will likely be individual decisions, arrangements, and compromises for the short term. Most specialties in the now “Balkanized” discipline of general surgery started out as “interest” foci. The academic track for global surgery seems to be on that same path. We can ask with Dr Nwariaku “Where to go from here?” The encouraging factors are that this quest is important; there is a very definite sense of perceived need, exceptional colleagues are already on the journey, and probably MOST IMPORTANT OF ALL—our younger generation WANTS to participate.

Commentary: Academic Surgery and Global Health

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From the Maurice Galante Distinguished Professor of Surgery Emeritus and Director of the University of California Global Health Institute, San Francisco, CA

It is timely and most appropriate that we discuss how and why academic surgery should engage in Global Health. We are indebted to the authors for raising this agenda for discourse.

Many universities, both private and public, appear to have developed a strategy to have a substantial and meaningful global reach in the 21st century. Within their programs of global health, surgery is the least represented discipline. As the authors state, a similar situation exists when one looks at the role of surgery in a global public health strategy in general. I will focus my remarks on why and how Academic Surgery should engage