PERSPECTIVES

International Clinical Epidemiology Network

An Opportunity for SGIM International Cooperation

Peter Tugwell, MD, MSc, FRCPC,^{1,2} Robert Fletcher, MD, MSc,^{3,4} Suzanne Fletcher, MD, MSc,⁵ Charlie Goldsmith, PhD,⁶ Mohammad Rahbar, PhD,^{7,8} Vivian Robinson, MSc,¹ Desmond Runyan, MD, MPH, DrPH,⁹ Laura Sadowski, MD, MPH¹⁰

¹Centre for Global Health, Institute of Population Health, University of Ottawa, Ottawa, ON, Canada; ²Ottawa Health Research Institute, Ottawa, ON, Canada; ³Harvard Medical School, Boston, MA, USA; ⁴The University of North Carolina at Chapel Hill, Chapel Hill, NC, USA; ⁵Department of Ambulatory Care and Prevention, Harvard Medical School, Boston, MA, USA; ⁶Department of Clinical Epidemiology & Biostatistics, McMaster University and Centre for Evaluation of Medicines, St. Joseph's Healthcare, Hamilton, ON, Canada; ⁷Department of Epidemiology, Michigan State University (MSU), MI, USA; ⁸Clinical Epidemiology Research & Training Center (CERTC), MI, USA; ⁹Department of Social Medicine, Professor of Pediatrics, University of North Carolina at Chapel Hill, Chapel Hill, NC, USA; ¹⁰Collaborative Research Unit, Departments of Medicine, Stroger Hospital of Cook County and Rush Medical University Chicago, Chicago, IL, USA.

The Canadian/American regional group of the International Clinical Epidemiology Network (INCLIN) invites SGIM members to join in an international network dedicated to improving health in low and middle-income countries and reducing health disparities in North America—not only because many goals and activities of the 2 organizations are compatible such as evidence-based medicine, mentoring, and training; but because collaboration between SGIM and INCLIN could strengthen both groups. With increasing brain drain from the developing world to the North, there is an everincreasing need for academic contributions from the North to swing the balance toward brain gain for the South. SGIM members have the academic expertise to make an important contribution to global health. Participation and contribution from SGIM members is welcomed at the individual or organizational level. We invite you to explore possible partnership and collaboration.

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The 2006 Annual SGIM meeting in Los Angeles dedicated 1 day to the role of primary health care in global public health. One of the participants on that day was the Canadian/American regional group of the International Clinical Epidemiology Network (INCLIN). Many SGIM members already know about INCLIN because INCLIN programs have been led by SGIM members at institutions such as the University of North Carolina, University of Pennsylvania, University of Toronto, Stroger Hospital of Cook County, and Harvard. We invite others to join too—not only because many goals and activities of the 2 organizations are compatible (which is not surprising as INCLIN training programs were patterned after the Robert Wood Johnson Foundation Clinical Scholars Program and other fellowship programs underpinning much of SGIM's science base) but because collaboration between SGIM and INCLIN could strengthen both groups.

International Clinical Epidemiology Network comprises clinical epidemiologists concerned with the availability, effec-

tiveness, and efficiency of health care in their home countries. Through carefully designed training, regular follow-up visits with mentors, workshops at local networks, involvement of senior administrators, and other support, INCLIN helps faculty in developing countries' medical schools to assess the factors that determine the most effective prevention and treatment strategies. Created in 1980 as a project of the Rockefeller Foundation, INCLIN has been an independent non-profit organization since 1988.¹ For 21 years, INCLIN has focused on helping clinicians and subsequently other scientists produce or obtain the knowledge and tools to improve the health of people in lower and middle-income countries (LMICs). Today, the membership includes over 1,400 individual members in clinical epidemiology units in 81 medical institutions in 41 countries throughout the world (Fig. 1).

International Clinical Epidemiology Network faculty includes clinical epidemiologists, health social scientists, biostatisticians, and clinical economists, each of whom believes that fighting disease in an age of limited financial resources depends on integrating the principles of clinical epidemiology into his or her own practice. International Clinical Epidemiology Network provides a forum for researchers to discuss critical health issues through educational programs, global meetings, and an international communications network. It supports young researchers and provides network members opportunities to participate in collaborative clinical studies. As a partnership of clinicians and health scientists who are trained to use and produce the best possible evidence in their medical decision making, INCLIN can have a profound impact on health care practices and policies globally. For example, INCLIN studies on short-course amoxicillin in pneumonia for children,² kangaroo mother care (an example of where the North learned from the South),³ World Studies of Abuse in Family Environments (WORLDSAFE),⁴ and rational drug use⁵ have resulted in improved health care practices and policies, both in LMIC and in the North.

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Address correspondence and requests for reprints to Dr. Tugwell: Centre for Global Health, University of Ottawa, 1 Stewart Street, Ottawa, ON, Canada K1N 6N5 (e-mail: elacasse@uottawa.ca).

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FIGURE 1. International Clinical Epidemiology Network Worldwide clinical epidemiology units and training centers.

International Clinical Epidemiology Network has now matured sufficiently, such that in 2000 it was decided to invite formal membership by industrialized nations—and under the leadership of Suzanne Fletcher (a past president of SGIM), CanUSACLEN was approved for full membership in 2001. The mission of CanUSACLEN is to establish a regional network of institutions in Canada and the United States, dedicated to training and collaborative research on health problems that are regional and global. CanUSACLEN members are convinced that many of the challenges facing health and health care of populations in developing countries are similar to those facing underserved populations in our own countries.

Institutional and individual membership in CanUSACLEN is welcomed (see www.CanUSACLEN.org). Joining CanUSACLEN provides immediate access to the worldwide INCLIN network of fellow investigators and groups. SGIM members already involved can testify to the rich professional and personal experiences that occur with such international collaboration.

The values of SGIM fit the objectives of INCLIN remarkably well, for example, excellence in patient-centered, scientifically sound medical care, research, and education, fostering collegial support and mentorship as well as interdisciplinary collaboration, adopting creative and innovative approaches to advance clinical care, teaching, and research. CanUSACLEN and SGIM also have a common interest in promoting social responsibility and the health of vulnerable, underserved, and diverse populations.

Furthermore, SGIM is increasingly committed to global health, demonstrated by the day at this year's annual conference devoted to the role of primary health care in global public health, health service research infrastructure in the developing world, the need to link SGIM with similar organizations around the world, and the role of general internal medicine in the fight against global epidemics such as HIV. CanUSACLEN members can contribute to these SGIM goals by linking SGIM members with relevant World Health Organization programs such as the Alliance for Health Systems and Policy Research,⁶

the evidence for information and policy cluster (WHO/EIP), the special program for research and training in tropical diseases (WHO/TDR), and the special program of research, development, and research training in human reproduction (WHO/TDR). Furthermore, CanUSACLEN and INCLIN members have played a key role in the development of the Mexico Statement on health research and health systems strengthening.⁷

How might informal or formal collaborative arrangements between SGIM and CanUSACLEN be of mutual benefit?

It seems clear that CanUSACLEN and INCLIN can certainly benefit from the expertise of SGIM members and perhaps INCLIN can contribute to a greater global involvement of SGIM, by providing links to a critical mass of clinical epidemiologists and other health professionals in LMICs.

Examples might include the following:

- (1) SGIM members could partner with INCLIN or its Regional Networks on the basis of mutual interests. CanUSACLEN could provide a matching service based on areas of interest:
 - Existing projects: For example, Bill Tierney (Co-editor for JGIM) and colleagues' work with the AMPATH Project (Academic Model for the Prevention and Treatment of HIV/AIDS in Kenya)⁸ could be linked with other members of Africa-CLEN. INCLIN multi-center studies might be of interest to SGIM members, for example, Salim Yusuf is leading a multi-center study on obesity⁹ and Don Silberberg is leading the Neurology International Partnership Program, which links 230 neurology departments in high-income countries with 235 departments in the developing world, to facilitate collaboration.¹⁰ Ongoing international epidemiology initiatives might provide an opportunity for collaboration, such as the National Institutes of Health (NIH) worldwide International Epidemiologic Databases for Evaluating AIDS (IeDEA) initiative, which is developing and maintaining epidemiologic databases in 7 regions, 5 of which are in LMIC.¹¹
 - Geographic interest. Interest in a particular country where the SGIM member has spent an elective or traveled.

- Multicenter projects. WORLDSAFE (World Studies of Abuse in Family Environments) led by Des Runyan and Laura Sadowski, which has tested its framework for assessing determinants of abuse in Brazil, Chile, India, Egypt, and the Philippines.¹²
- Teaching expertise, particularly in the areas of problem-based learning, virtual learning, evidence-based health care, and policy. Some common interests that could be explored and where there is interest from funding agencies are medical errors, reporting/surveillance of adverse drug reactions, practice variations, and equity issues in health care provision.

(2) INCLEN is keen to develop a "south-oriented virtual campus" for providing state-of-the-art multidisciplinary training that will build indigenous health research capacity and provide courses and mentoring support for the acquisition and regular upgrading of the skills and competencies of individuals in their home countries. This virtual campus builds on INCLEN's ongoing efforts in developing online learning modules as part of the Leadership and Management Program (LAMP)¹³ as well as the Knowledge Management Plus Program, which is developing locally relevant, equity-focused clinical practice guidelines.¹⁴

Partnership with SGIM members in developing the virtual campus would be warmly welcomed. This might be relevant to the SGIM Evidence-Based Medicine (EBM) Task Force led by Scott Richardson, whose mandate includes continued improvement of the EBM website, including the addition of new downloadable resources as well as developing an online EBM curriculum.

Furthermore, CanUSACLEN and INCLEN can contribute to SGIM's focus on health service research infrastructure in the developing world, with their experience in control program evaluations, quality improvement, rational drug use, and health care financing.

(3) Link informally and formally with other SGIM Task Forces with mutual interests. For example, the SGIM Disparities Taskforce, led by Donna Washington, aims to continue with the Career and Faculty Development project in health disparities education, including organizing development workshops in various locations nationally and to develop a textbook or curricular handbook on health care disparities. For example, members of CanUSACLEN have launched a collaborative research project on addressing disparities in diabetes management in Canada, the USA, and developing countries, led by Russell Harris.

This could be linked to the INCLEN Knowledge Management Plus project, which has developed an equity lens to appraise clinical practice guidelines with leadership from Antonio Dans, and contributions from CanUSACLEN members, Peter Tugwell and Vivian Robinson. Members of CanUSACLEN and INCLEN are leading the development of a Cochrane Collaboration field on equity and effectiveness of interventions.¹⁵

Collaboration with the SGIM interest group on international health, led by John Peabody, might explore how general internal medicine is influencing health care practice in the developing world. For example, Antonio Dans, an INCLEN fellow, established a new Section of General Internal Medicine under the Department of Medicine of the University of the Philippines—Philippine General Hospital. Evaluation of similar Sec-

tions/Departments established in INCLEN centers/institutions might be an area of mutual interest in which SGIM members might contribute.

(4) Somewhat more formal relationships between institutions might be developed for joint project submissions in response to requests for proposals from the NIH, other U.S. and Canadian funding agencies, and funding agencies in other industrialized countries. CanUSACLEN might play a role in matching SGIM interests with relevant Regional INCLEN networks.

(5) A formal partnership between SGIM groups in northern institutions and INCLEN and Regional CLENs might be developed with an Memorandum of Understanding that involves student and faculty exchanges.

(6) The 2 organizations could take this 1 step further by working together to test 1 of the 5 scenarios suggested by the International Campaign to Revitalize Academic Medicine (ICRAM), namely that of the Global Academic Partnerships (GAP) to address the 10/90 gap.¹⁶ The 10/90 gap was coined in 1990 when the Commission on Health Research for Development identified that 10% of global health research resources are spent on 90% of the world's health problems.¹⁷ Despite increases in global health research spending, the 10/90 gap persists. The GAP scenario is envisaged as a combination of all the above collaborative activities but requires a more substantive commitment to a meaningful partnership over a decade or more, to focus on addressing 1 or more major pieces of the solution to the 10/90 gap (e.g., academic medicine workforce avoiding the brain drain, evidence implementation, and knowledge translation in partnership with governments or non-governmental organizations that ensures benefit for the disadvantaged).¹⁶

With increasing brain drain from the developing world to the North, there is an everincreasing need for academic contributions from the North to swing the balance toward brain gain for the South. SGIM members have the academic expertise to make an important contribution to bridging the 10/90 gap. Participation and contribution from SGIM members in INCLEN or CanUSACLEN is welcomed at the individual or organizational level. We invite you to explore possible partnership and collaboration. Please visit us at: www.canusaclen.org.

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