possible. Medical students don't care about learning for learning's sake; they want to learn the knowledge and skills that will truly matter to them in their career.

This scenario also highlighted the issue of multidisciplinary work. Medical students are not formally taught to relate to or work with other health-care professionals. Although multidisciplinary work is far from being a major concern on the agenda, it will become increasingly important in the future. Perhaps as a sign of the changing times, medical students can look forward to the first world medical and pharmacy students' joint symposium later this year.²

In the United States, medical training is already trying to cater for students' differing needs and motivations, and taking into consideration the importance of interfacing with other areas of knowledge. Universities offer combined programmes such as MD/MBA (business), MD/JD (law), or MD/PhD.³ I hope evolution will not halt here and that what we have

now is simply the embryonic stage of what in the future may become the effective "niche training" envisioned in Academic Inc.¹

Each country or medical system (be it at government or medical students' association level) can draw plenty of inspiration from these scenarios when planning an overhaul of academic medicine. The magic formula to raise academic medicine from its hospital bed is likely to consist of a mix of the ingredients from all the scenarios. The magic lies in knowing which proportions of each of these ingredients work best.

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Commentary: How far is the future?

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How far is the future? Not that far, really, since the present contains many of the elements featured in the five International Campaign to Revitalise Academic Medicine (ICRAM) scenarios.¹ The problem is that we have the worst possible combination: market rules dictating where to go in a world where most people are not even part of the market; an academic environment in which everyone is torn between conflicting demands; and scientists who have second thoughts about mingling with other sciences and dread being in the public eye.

The good thing is that the seeds for change are also here. And while no single scenario will dominate over the next decades, much can be done to turn the tide. The international working party group has laid the foundations.^{2,3} We now have to roll up our sleeves. Research bugs as we are, we could start by probing into the apparently harmonious world of academic medicine. We might find out that we have been part of different worlds with colliding interests—scientific and political. The ICRAM initiative is a good occasion to recognise these conflicts and start working them out.

Achieving global equity

Looking from the developing world, we should clearly avoid the unbridled and truly global dominance of the private sector, which will not narrow the 10:90 gap and will certainly deepen the brain drain. But are scientists in the developing nations really willing to go against the grain of their governments and their markets, currently geared towards the commercially induced needs, anxieties, and expectations of their populations? We cannot take this for granted because we have increasingly become the task force of big corporations, and medical education flourishes in and for the private sector.

Rich countries will have to take the lead. It would be naive to expect leverage from poor countries with no budget for academic research and diminishing

Global academic partnership

allocations for higher education. Most research in the developing world depends on external aid and agendas, and part of that money ends up being used for other purposes.

So what have we got to build on if we want to go in the direction of global health equity? We have landmarks such as the Global Forum for Health Research and the millennium development goals, which bind countries together in the fight against poverty, illiteracy, hunger, lack of education, sex inequality, child and maternal mortality, disease, and environmental degradation.⁴ But we also have colliding values and priorities that we should tackle if we want to move on. This will require leadership, though we should not mistake leadership for self reverence. This is the other great challenge in the academic world.

The good thing about most of the ICRAM scenarios is that they throw us into a messy reality of

partnerships, alliances, negotiations, and, yes, other types of knowledge. Are we ready to embrace this world with all it entails? The time has come for us to grow, but we will never grow alone.

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Commentary: Challenging the patience of patients

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Academic medicine has a critical role in consumer health care. Patients can thank academic medicine for research leading to improved health care, education of medical professionals, and leadership in patient care, research, and education. But times have changed. The growing disincentives to participate in academic medicine and demanding financial, political, demographic, consumer, and technology trends are cause for concern. If academic medicine is to remain a leading player in the business of health, it has to do better.

I applaud the International Campaign to Revitalise Academic Medicine for prompting strategic introspection and global action.¹ Patients have had an integral role in the campaign from the start and will continue to contribute. But is that enough? Can we afford to wait for the results of this strategic process or should we demand more of policy makers and academic medical centres now?

The five scenarios offer us a pathway to examine old models, think outside traditions, and ask ourselves why and how academic medicine will thrive in the face of reduced resources, increased competition, departmental disparities, and emergence of potentially conflicting driving forces. These scenarios are intentionally pithy and provocative. If change is going to happen, we will all have to let go of preconceived notions and focus on the recovery of academic medicine.

Strategic lessons

Change at the international level evokes political trauma, multinational differences, and conflicting community priorities. The changes required within academic medicine have many parallels with those I have been involved with as part of the Bone and Joint Decade 2000-2010, a UN endorsed initiative to improve the health of people with musculoskeletal disease.² The strategy is to "think global, act local," and patients have a fundamental role in initiatives to increase research funding and development, improve medical and patient education, and empower patients.³ The ultimate voice is, in fact, the patients.

The main lesson from the UN initiative is to include all stakeholders at every stage of the process, starting with the development of a statement on the need for change, an integrated vision and mission, core concepts, and objectives. Other stages include:

- Identifying multidisciplinary opinion leaders in selected countries to facilitate national dialogue among groups representing the stakeholders

Fully engaged

- Getting stakeholder groups and policy makers to endorse the vision, core concepts, and desire for change
- Bringing stakeholders together to identify national and regional priorities and commit to action.

The academic medicine campaign will also need to encourage funding bodies to offer incentives for innovative ideas and demonstration projects in individual countries. An international steering group is essential to promote implementation of evidence both within and across countries, motivate stakeholder groups, guide resources for national developments, and mark important achievements.

Efforts to revitalise academic medicine must incorporate the patient as a stakeholder in all strategic and action groups. Change is a challenge, but it gives patients and other partners a chance to participate and benefit. Patients can no longer afford to be patient. When academic medicine thrives, we all win.

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