Barriers to global surgery academic collaborations

TO THE EDITOR: We read with keen interest the recent article by Fallah and Bernstein (Fallah PN, Bernstein M: Barriers to participation in global surgery academic collaborations, and possible solutions: a qualitative study. *J Neurosurg* [epub ahead of print April 6, 2018. DOI: 10.3171/2017.10.JNS17435]). We commend the efforts of the authors in carrying out this study, especially for suggesting solutions to the barriers between surgeons in high-income countries and those in low- and middle-income countries as revealed by the study.

In addition to their suggestions addressing some of these barriers, we additionally propose a couple of other ideas, which we believe might be useful for participants in such collaborative programs. First, regarding concerns over the follow-up care that patients would receive after surgical care in low- and medium-income countries, we suggest maximal utilization of various forms of telemedicine available in such settings for follow-up and continuation of patient care, such that surgeons coming from high-income countries would not necessarily need to be physically present during the postoperative period to effectively follow up on patients after surgery, thereby significantly shortening the time spent on international collaborative work and, hence, solving not only the problem of loss of income due to long periods away from one’s primary job but also the issue of too little time for family and vacation. Second, while we agree with the authors that a similar study such as this should be carried out to examine the peculiarities of difficulties being faced by such collaborations from the perspective of those in both low- and medium-income countries, we would like to point out that results from a recent Africa-based study to assess the interest of neurosurgeons based in low- and medium-income countries in various global surgery initiatives revealed that most neurosurgeons who participated from 21 different African countries not only believed that their training program was inadequate but were also interested in improving it through international collaborations. In fact, findings from that study and those reported in other publications strongly suggest the value of more interest and emphasis on training, compared to other various benefits arising from such international collaborations. Online education, shared surgical videos, and recent innovations such as telesimulation supplied through remote internet access can be used to teach not only simple but also complex procedural skills to neurosurgeons and trainees based in low- and middle-income countries, and in this way, surgeons coming from high-income countries for such collaborative efforts would not necessarily need to be physically present all the time for such procedures.

Although their suggested solutions to the issues as revealed by the study may not completely address all the concerns (such as the issue of insecurity due to war and terrorism in politically unstable countries, as well as high rates of infectious transmissible diseases prevalent in some low- and middle-income countries), practical steps by the governing health body in high-income countries to make and implement policies that take these proposals into consideration would certainly go a long way in fostering the development, growth, and progress of such collaborations.

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Disclosures

The authors report no conflict of interest.
Response

We are grateful for the recent letter by Onyia and Ojo regarding our article. Their suggestion for maximal utilization of telemedicine for follow-up and continued collaboration is an important one. Given the increasingly technological age that we currently live in, it has become possible for partnerships to form and for increasing advances in surgical care to happen at further distances. Increasing the use of telemedicine and technology can potentially reduce the amount of time spent abroad for international collaborative work, thus decreasing periods of time spent away from one’s primary job and home life. This could address some of the barriers to global surgery work that were pointed out in our study. However, it is still important that we continue to push for the overall field of surgery to accept global surgery as an important academic endeavor, such that rather than these collaborations being an “extra” part of one’s career, surgeons could instead dedicate their full academic time to this work, thus relieving strain on their personal lives and encouraging more involvement in the field.

The Africa-based study that Onyia and Ojo pointed out looked at the interest of neurosurgeons in being involved in international collaborations. That study’s increased emphasis on training supports the need for partnerships and sustainable global surgery efforts. We agree that in addition to global surgery collaborations, universally available and standardized education in surgery could decrease the amount of time needed to be physically present in lower- and middle-income countries. However, our hope is still that global surgery will be increasingly valued as a career, and this will create the opportunity for physical presence in low-resource settings worldwide, both locally and internationally, to facilitate connections and to foster the development of infrastructure beyond clinical training.

As mentioned by Onyia and Ojo, we suggested solutions for many of the barriers facing surgical healthcare providers who want to be involved in global surgery academic collaborations as a major component of their careers. Although not all barriers can be easily addressed, we ardently hope that academic institutions, professional organizations, and especially our own surgical, obstetric, and anesthesia colleagues will value global surgery as an important endeavor and will implement changes to facilitate careers dedicated to the field.

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