

## Better Allocation and Sharing of Resources in Global Medical Education

**To the Editor:** I appreciate that Farmer and Rhatigan<sup>1</sup> advocate greater involvement of U.S. academic institutions in strengthening medical education in low- and middle-income countries (LMICs) however I would like to draw attention to two issues they did not address.

First, I would have liked for the authors to have explicitly cautioned against the unthinking import of Western curricula and accreditation systems into LMICs that fails to take adequate account of local contexts.

Second, while many agree that U.S. governmental funding for health education in Africa has had a positive impact, how such funding has been allocated and distributed remains contentious. The Medical Education Partnership Initiative's (MEPI's) original five-year awards of \$130 million to just 13 institutions in 12 countries should have been more equitably awarded and distributed.<sup>2</sup> MEPI contended that their original network ultimately expanded into a larger network of collaborating schools.<sup>3</sup> While such an expansion did indeed occur, the extent to which the awarded funding was disbursed more widely is questionable, especially with respect to institutions in countries not included in the original awardee network. The authors point out that 17 countries in sub-Saharan Africa have only 1 medical school—only 1 such country (Botswana) was included in the original MEPI awards. The hope is that a new round of funding will be more widely and equitably distributed to include institutions outside of the original MEPI network.

Farmer and Rhatigan and others commend efforts to establish new medical schools because of their potential to be innovative. A more compelling reason for supporting new medical schools (especially in Africa) is that they are often established in remote areas of a country where medical services are desperately needed. In such low-resource settings (LRSs), there are few guarantees that new schools will succeed given the general inadequacies of rural facilities and the associated difficulties in recruitment and retention of faculty. New medical schools in LRSs deserve special attention

and support. Given the burden of disease and the severe shortage of physicians and health care workers in these settings, failure should not be an option.

The authors praise U.S. government funding support and the faculty who commit their endeavors to select institutions in Rwanda, Haiti, and elsewhere. While such support and commitment are important and welcome, concentrating efforts on only select institutions in a country can in some settings have adverse consequences for less-favored facilities, such as siphoning away staff, patients, and funding. Is there a more socially accountable model for funding allocation and distribution of resources in LRSs of LMICs?

*Disclosures:* None reported.

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### References

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- 2 Eichbaum Q, Nyarango P, Bowa K, et al. "Global networks, alliances and consortia" in global health education—The case for south-to-south partnerships. *J Acquir Immune Defic Syndr.* 2012;61:263–264.
- 3 Olapade-Olaopa EO, Baird S, Kiguli-Malwadde E, Kolars JC. Growing partnerships: Leveraging the power of collaboration through the Medical Education Partnership Initiative. *Acad Med.* 2014; 89(8 suppl):S19–S23.

**In Reply to Eichbaum:** We thank Dr. Eichbaum for his close reading of and comments on our article. The issues he raises are important, and his points are insightful: We agree with them all. Our goal was to advance the argument that U.S. medical schools should make the bolstering of medical education in low- and middle-income countries part of their missions. We chose to highlight successful partnerships and initiatives that are accomplishing this goal to encourage U.S. academic medicine to reimagine its medical education mission within a global context and to nudge the many medical schools that are

considering such engagement into action. We agree that these efforts needs to be pursued with a deep respect for local context and expertise; with an equity agenda that aims to remediate the many historical, economic, and social forces that have left some nations bereft of health professional education; and with a profound humility that acknowledges our own immense privilege.

We have both been fortunate to be part of the team that is creating a new medical school in Rwanda at the University of Global Health Equity under the leadership of Dr. Agnes Binagwaho, Rwanda's former Minister of Health. The planned medical school will be located on the university's remote, rural campus and will be affiliated with three government-run district hospitals. It will use the latest innovative and evidence-based teaching methods to train physicians who have skills to lead and manage health systems with an emphasis on equity, and it will draw heavily on lessons learned from Rwanda's transformation of its health system. It has the support of the Government of Rwanda and will influence national human resources for health strategic planning. While it is only one school, in one country, we hope that it can serve as a model for what is possible. And we whole-heartedly agree that "failure should not be an option"; there are too many lives at stake.

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## The Motivational and Evaluative Roles of NBME Subject Examinations

**To the Editor:** Ryan and colleagues<sup>1</sup> recently examined the validity of using National Board of Medical Examiners (NBME) Clinical Science subject examinations as a factor in determining clerkship grades. The authors interpreted a significant association between United States Medical Licensing Examination (USMLE) Step 1 scores and subject examination scores as