quadriplegic and without the ability to speak, but completely conscious. He shares his story on p 94. Interspersed with Nick's narrative, Grant Gillett provides information on this rare medical condition and discusses clinical and ethical issues that arise in locked-in syndrome.

MALCOLM WILLETT

## Academic medicine, where are you headed?

Will academic medicine in 2025 be the pillar of medical advancement, a long forgotten historical scribble, or something in between? Who knows; as Clark says on p 101, it is impossible to predict the future. ICRAM, the international campaign to revitalise academic medicine, created a team to develop a vision for the future of academic medicine. The five resulting scenarios aim to enable richer conversations by stretching thinking on what the future might bring.

## POEM*

### Don't use hip spica in kids with femoral fracture

**Question** Is external fixation more effective than hip spica casting in preventing malunion in children with femoral fractures?

**Synopsis** Children aged 4-10 years who were admitted to one of four paediatric hospitals with diaphyseal femoral fractures were randomly assigned (concealed allocation) to early application of hip spica (n = 60) or to external fixation (n = 48). Physicians unaware of the patient's treatment regimen and previous assessments. The researchers evaluated the children three months, nine months, 15 months, and 24 months after the fracture; the patients wore tights to the evaluation to mask treatment allocation. Follow-up accounted for 94% of the patients at the end of the study. Fracture malunion occurred in 45% of the patients in the hip spica group and in 16% in the external fixator group (number needed to treat = 4; 95% CI, 2.2 to 8.3). The average time the child was immobilised with a hip spica or used the external fixator was 77 and 58 days, respectively (P = 0.001). Nearly half (45%) of the children treated with the external fixator developed pin tract infections requiring oral antibiotics (number needed to treat to harm = 3), but none required hospitalisation. There were no differences in the secondary outcomes.

**Bottom line** External fixation of paediatric diaphyseal femoral fractures significantly prevents malunion two years after fracture compared with early hip spica application. Because of the very high malunion rate, primary care physicians should stop placing these patients in hip spica casts while patients are waiting to see an orthopaedic surgeon. Instead, they should arrange for rapid orthopaedic consultation.

**Level of evidence** 1b (see www.infopoems.com/levels.html). Individual randomised controlled trials (with narrow confidence interval)

Wright JG, Wang EE, Owen JL, et al. Treatments for paediatric femoral fractures: a randomised trial. *Lancet* 2005;365:1153-8.



* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

## *Editor's choice*

## Where are the leaders?

Got the wrist band, got the "Make Poverty History" T shirt, and glad to have been in Edinburgh among what Colin Douglas calls "the marching innocents" (p 117). At the time of writing it's not clear what, if anything, will come out of the G8 summit, so naive optimism is still, it seems to me, a legitimate option.

The same won't do for academic medicine. Long taken for granted as medicine's indispensable research and teaching arm, academic medicine is now the focus of international concern, a sick patient with an uncertain prognosis. The diagnosis is becoming clear, thanks to the work of a global campaign to revitalise academic medicine launched by the *BMJ* and partners in 2003, which reports back this week (p 101). Academic medicine lacks vision and leadership. It is failing to engage with the real issues of health care and failing to attract the best young recruits.

It's hard to think about academic medicine in the abstract. Who are these academics and what do they do? A simple definition is that they are people who do at least two of three things related to medicine: research, teaching, and clinical practice. Over the years, as Jocalyn Clark explains, they have helped us to think, discover, evaluate, learn, and improve. Without them, we would not have recognised the link between smoking and lung cancer or the need for early treatment after myocardial infarction. Without them, we are unlikely to find cures for cancer or vaccines for HIV and malaria. A future without strong global academic medicine is hard to imagine.

But that is what's in store, according to the campaign, unless something radical is done. The question is, what and by whom? To help find an answer, the campaign working group has developed a series of scenarios that illustrate alternative futures. They provide an opportunity to steer a new course towards greater engagement with the public, greater global equity, incentives for innovation, mentoring and support for young academics, flexible career paths, robust institutions with secure long term funding, leadership, and vision for academic medicine around the world.

The five scenarios are not mutually exclusive. Nor are they entirely futuristic. As Sally Davies points out in her commentary (p 105), elements from the scenarios are already discernable. Zulma Ortiz (p 106) thinks we already have the worst possible combination from each scenario but acknowledges that the seeds of change are also here. Karen Sliwa-Hahnle gives a formidable account of how to succeed in today's climate (careerfocus.bmjjournals.com). Tiago Villanueva calls for practical hands-on education for medical students (p 105), something that Benson and colleagues report is acceptable to patients in general practice (p 89). Amye Leong (p 107) speaks for patients and all of us in saying, "When academic medicine thrives, we all win."

These entertaining scenarios are at root deeply serious, reflecting a crisis at the heart of academic medicine. The debate presents a clear challenge to the people currently in leadership positions in academic medicine. Step up to the plate and engage with the issues. Or step down.

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