
LETTER TO EDITOR

What Is the Best Research Globally?

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Dr. Afshari's editorial gives insight on human nature (1). Collaborative willingness usually occurs when different sides perceive personal benefit, or when institutions mandate collaboration. This is not unique between higher and lower income countries; many working in global emergency medicine (EM) observe this within wealthier countries. It exists among collaborators in low resource settings. Yes, pride and status are globally universal. Convincing others to engage altruistically is challenging.

Camaraderie and "brotherhood" is created from shared experiences. Many global health practitioners work for extended times overseas, returning to their own countries with new perspectives and gratitude, if the experience was positive. As mentors, we must identify young physicians and investigators with these attributes, and create positive outcomes. Then, it is imperative to continue the relationship. Commitment is therefore needed. The Global Network of Emergency Medicine had its second meeting in Dubai in May 2013, in order to promote this idea, without making one country adhere to the system of EM of another country-in other words, EM and research is set according to autochthonous needs (2).

Project funding remains difficult. In the US, the National Institutes of Health grant 5% of their budget to EM research. Yet the NIH will claim that 23% of their funding goes to emergency medicine research. Why the disparity? Occasionally, primary investigators from other specialties use our departments as their "laboratories", leaving EM specialists outside of a given large, prospective, randomized study (much of the cardiology literature published in the New England Journal of Medicine has few of our specialists included) (3,4). Furthermore, our research methodology may be lacking, since the majority of designs are case

controlled, and fewer studies overlooked by powerful funding agencies. Many funding agencies don't understand EM priorities. Donors may be non EM trained philanthropists, or bureaucrats. Decision maker physicians are also rarely EM (5), let alone toxicology trained. Either change funding demographics, or look southward.

In Mexico, PACE (<http://www.pace-medspanish.org>) monies come from those personally affected by emergencies or from governments wishing to improve health statistics (example: decreasing infant-maternal mortality). These community-based programs help funders reach their goals, and fund us to spread EM rurally. A Latin-American "southern" alliance exists, with the "brotherhood" of US EM organizations (ACEP).

With global economic uncertainty looming, well-developed regions can benefit from programs originating from limited resource settings. Many of us believe altruism, a communal bond or desperate needs, is able to link the North and South together.

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