Engagement versus Isolation: Lessons from the Eurasian Medical Education Program

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The Eurasian Medical Education Program (EMEP) was established in 1995, during a time of political and economic turmoil in Russia. Created in partnership with the American College of Physicians, it was designed to share clinical and scientific knowledge with Russian physicians.

Background

The EMEP was aimed generally at illustrating the importance of health as an instrument of political and diplomatic engagement. Such engagement between the United States and Russia has indeed varied since the fall of the Soviet Union—sometimes encouraged, other times discouraged by one or the other nation. Guiding such cycles in both countries were a range of political forces as well as deep-seated cultural differences. In particular, in 1999, the initial enthusiasm for a better life under a market economy in Russia was replaced—during a severe economic crisis—with disaffection.

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During the early 1990s, many several prominent individuals and institutions contemplated the fragility of the new Russian state and its importance for maintaining economic and social stability domestically and beyond.\textsuperscript{1, 2, 3, 4} Proposals emerged for new Marshall Plan-type initiatives to ease the new nation through a difficult economic transition.\textsuperscript{5, 6, 7} The American economist Jeffrey Sachs, noting that Russia had inherited the external debt held by the Soviet Union, predicted that economic and social shocks would accompany the transition to a democratic society and a market-based economy. He thus proposed a $27 billion fund to be derived from U.S. national and multinational sources. An important part of this initiative was a “social fund” directed toward healthcare needs.\textsuperscript{8} During this period, much attention was given to worrisome demographic trends in Russia. Deaths exceeded births, fertility had dropped, and premature mortality was high, particularly among younger men. As a result, Russia was losing 400,000 to 600,000 persons per year net of any in-migration from the former Soviet republics.\textsuperscript{9}

An overbuilt but physically deteriorating healthcare system was thus characterized by declining indices of health yet supported by a meager national expenditure of 4 percent of a relatively small GDP.\textsuperscript{10} From the time of Russia’s 1917 revolution, physicians were remunerated at just 70 percent of the average industrial wage, a level at which they remained over the next seventy-plus years.\textsuperscript{10} The country had, however, enjoyed a tradition of prevention and a healthcare structure that extended the reach of resources across the country’s vast reaches.

The concept of the EMEP arose from a single driving factor: the need for an intervention that could contribute substantially to the health sector in Russia. For the previous several decades, most Soviet medical practitioners had been relatively isolated from Western medicine, suggesting an opportunity to share knowledge, skills, and contemporary care standards with the Russian medical community. Universally, the practice of medicine requires periodic postgraduate or continuing medical education. The architects of the EMEP thus proposed a concept of sharing experience, skills, and knowledge with Russian physicians in the spirit of such continuing education.

When President Putin declared an end of U.S. programs receiving funding from USAID in 2012, I served as the director of the EMEP. Earlier, while a member of the staff of the President’s Science Advisor —the precursor to the Office of Science and Technology Policy—I had helped develop cooperative programs in medicine, science, and the environment with the Soviet Union during the détente period, when U.S.-Soviet tensions had eased from their earlier heights.

A few other events helped shape an early framework for the program. The first occurred in 1992, when Secretary of State James Baker convened the Washington
Coordinating Conference on Assistance to the New Independent States, an effort aimed at determining appropriate humanitarian assistance for the former Soviet Union. From this grew an initiative known as the Medical Working Group Experts Delegation to the Newly Independent States, which consisted of thirty healthcare professionals from thirteen countries who visited medical institutions and public health authorities in ten of the former Soviet republics, seeking to ascertain what these institutions needed. While identifying areas for contribution to Russia’s medical and public health sectors, the delegates acknowledged that humanitarian assistance could have an “anesthetizing effect” on recipients. To this effect, at every stop, Russian hosts admonished the delegates to reduce financial humanitarian assistance but rather to “help us help ourselves.”

The Role of Partnerships

A key element in the ultimate success of the EMEP was its partnership agreement with the American College of Physicians (ACP), a medical professional organization founded in 1915 that, as of 1995, included 130,000 physician members trained in internal medicine. The EMEP leaned primarily on the ACP as a source of selected physicians to travel to Russian academic medical centers. This effort in Russia also marked the ACP’s first action-oriented endeavor abroad.

The program’s early phases included developing the following series of organizing principles:

- **Focusing on Russia’s geographic regions.** The early decision to concentrate EMEP activities in regions outside Moscow was pivotal to its effectiveness in bypassing the political overlay that inevitably marked transactions in the capital. Further, this focus on the regions was aided by a new health insurance law enacted in 1993 that redistributed a substantial portion of healthcare funding away from Moscow, increasing both the political and economic power of the regions.

- **Bringing clinical-scientific information and professional skills to Russian physicians.** Early on, Russian colleagues expressed a desire to better understand the biological mechanisms of disease and evidence-based interventions for management of disease.

- **Facilitating personal interaction among physicians.** American physicians traveled to Russian regional academic medical centers to share experience and knowledge with their Russian counterparts. Although some had suggested that clinical information be transmitted to the Russian physicians by electronic means, the program’s architects concluded that the value of professional exchanges transcended any economic benefits to be derived from electronic transmission.
• **Selecting physician experts based on recognized professional accomplishments.** American physicians were chosen for the program based on a recognized record of achievement in their field. Additionally, program physicians were accepted for their teaching excellence, experience in foreign medical cultures, and, in some cases, Russian-language skills. Such an approach ultimately resulted in the enlistment of some fifty highly respected U.S. physician experts.

• **Diversifying funding sources.** Roughly half the financial support for the program was derived from the U.S. federal government and half from the private philanthropic sector.

• **Avoiding the use of the term “training.”** The designers of the EMEP insisted on hewing to the concept of sharing knowledge and experience with professional colleagues

• **Assuring continuity.** Continuity of effort and reasonably long-term commitments were regarded as very important. Professional relationships with the medical leadership in the Russian regions were thus based on an understanding that continuity would be maintained.

The EMEP began with a series of meetings with key members of the Russian Federation’s Ministry of Health and the Moscow State Medical Academy. The goal was to seek agreement on general program outlines, select regions to be served, and determine the medical and scientific material to be shared with the Russian medical community. The Health Ministry emphasized the importance of focusing on evidence-based medical interventions and urged that ways be found to extend the educational material to even larger groups of physicians across the federation.

### Initial Implementation and Expansion

In selecting regions, the two top criteria were: (1) the presence of an academic Russian medical center of recognized domestic standing; and (2) an expressed desire by the region’s political and medical leadership to participate in the program.

Of the five regions initially selected, three were in western Russia (Tula, 125 miles south of Moscow; Ekaterinburg in the Ural Mountains and Kazan, 500 miles east of Moscow on the Volga River, and two in the Russian far east (Khabarovsk, 250 miles north of Vladivostok; and Birobidzhan, on the Trans-Siberian Railway, close to the Chinese border). Initial overtures in each case included meetings with the regional governor—or president, in the case of Kazan, Tatarstan—and key members of the academic medical leadership. Participants in these candid
explorations discussed what the program might bring to the region and who would serve as a representative.

The five regions soon grew to thirteen, stretching almost entirely across the federation’s eleven time zones, from the Leningrad oblast (the area surrounding St. Petersburg) to Khabarovsk and Vladivostok in the far east. Medical experts visiting the regions spent a week lecturing and engaged in clinical teaching rounds. Clinical subjects examined in the rounds usually were cardiovascular disease, diabetes, tuberculosis (TB), or HIV/AIDS. In many cases, these visits were designed to coincide with existing Russian continuing medical education programs, thereby enhancing the American experts’ understanding of Russian clinical practices.

Accomplishments

The original program goal was to share U.S. experience and knowledge with the Russian medical community and, by extension, enhance the ability of practitioners to manage serious diseases. The achievement of this goal was evaluated according to (1) the extent to which material presented was understood and retained by the Russian hosts; and (2) changes observed in physician practice patterns and alterations in health status following the individual sessions. In cooperation with departments of epidemiology and statics in the Russian centers, patient charts were monitored over time to determine if physician practice patterns had reflected the educational material and to determine trends of health end points.

The contribution of non-communicable diseases to premature or excess mortality exceeded the impact of the prominent infectious processes (TB and HIV/AIDS) combined. Two principal risk factors underlay this statistic: cigarette smoking and unrecognized, untreated vascular hypertension. The EMEP established pilot programs in the Tatarstan republic, Sverdlovsk oblast, and Khabarovsk krai, which aimed at reducing blood pressure over a three-year period. The results of these pilot programs were a reduction in the prevalence of important risk factors and complications. Similarly, cohorts of more than five hundred diabetes patients were followed over a period of several years. The EMEP, through its educational work, thus appeared to aid in the prevention of diabetes and diabetes-related complications.

The AIDS and TB epidemics were more complicated due to traditions of Russian medical practice, economic issues, and, in the case of HIV/AIDS, significant social stigma. AIDS in Russia reached epidemic proportions in 1996–1997. During the first decade of the twenty-first century, between 100,000 and 150,000 new TB cases were reported in Russia, rendering it the country most burdened with the disease out of twenty, according to the World Health Organization. In Russia, drug-resistant
TB increased from 2 percent to 16 percent, with the prevalence particularly high among prisoners.

Tuberculosis in Russia presented notable challenges. The traditional pattern of TB management in Russia included confinement in bed for periods lasting up to years. This contrasted with much shorter periods of treatment of ambulatory patients using few drugs in the western world. In Russia, surgical intervention was heavily relied upon. Large hospitals and their staffs in Russia perceived a move away from traditional treatment patterns as an economic threat. An additional challenge came from the release into the community of large numbers of prisoners with active TB without adequate follow-up and treatment. As a result, such communities were constantly buffeted with new sources of infection. The EMEP concentrated on modern methods of screening, case-finding, diagnosis, and characterization of infecting organisms. For the Russian TB epidemic, the program’s singular contribution was in demonstrating the importance of rapid and valid microbiological diagnosis to guide appropriate therapy.

HIV/AIDS reached epidemic proportions in Russia in 1996-1997. The association of HIV/AIDS with patterns of risky behavior. These patterns of risky behavior sharply influenced the views of the Russian government and the medical profession. AIDS was associated with criminal activity and demanded a legal response rather than a public health solution. Co-infection with TB was very common. At the same time, the compartmentalization of Russian AIDS specialists away from other infectious disease departments discouraged integrated management.

The principal contribution by the EMEP was to share with infectious disease physicians’ principles guiding the diagnosis and treatment of AIDS, the use of anti-retroviral agents and highly anti-retroviral therapy for resistant organisms, and the management of co-infection with tuberculosis. One particular success was the management of HIV infection in pregnancy preventing infection in offspring. On another level, the EMEP played an important role—along with other nongovernmental organizations—in encouraging the Russian government toward more aggressive action to tackle the AIDS epidemic.

The EMEP collaborated with Rotary International in Russia. By 1999, there were seventy Rotary Clubs across the Russian Federation - the majority in Siberia and the Russian Far East. The EMEP joined forces with Rotarians in a series of public health-related and public education “health fairs” in several Russian cities. These were citizen sponsored demonstrations of important health issues including the serious consequences of risky behavior. The EMEP also collaborated with the Japan-Russia Medical Exchange Foundation - a Japanese professional organization.
with similar goals. This collaboration led to joint presentations in Khabarovsk, Niigata (Japan), and at the John Sloan Dickey Center at Dartmouth College.

Conclusion

Over the seventeen years of Eurasian Medical Education Program operations, U.S.-Russia ties vacillated dramatically, often raising questions about how the program fit into the diplomatic relations between the countries. The EMEP entered the scene at a critical point in U.S.-Russian bilateral relations. The program maintained strong ties with members of Congress with key roles in U.S.-Russian relations, with offices in the U.S. Department of State and the National Security Council in the White House. All officials involved recognized the importance of engagement and the role of health-sector cooperation in that engagement. Quasi-independence and flexibility afforded by private financial support was unquestionably paramount. Private supporters of the program included individuals and institutions that sought energetically to further trade and investment in Russia and, most important, to ensure social stability and security interests.

Notwithstanding the changes and, at times, turmoil that marked U.S.-Russia relations during the EMEP years, the program pursued an uninterrupted and active engagement with Russia immune to any adverse or diverting political influence. The program expanded from the original five to thirteen regions stretching across nearly all of the eleven time zones of the Russian land mass. Our Russian colleagues consistently encouraged us to expand and extend our activities both in substance and geography. Over its seventeen years, the program reached well in excess of 10,000 Russian physicians in Russian centers. The program received strong support and respect from high levels of medical and political leadership in the country. American visiting physicians were awarded academic recognition. As Director, I was elected into the Russian Academy of Medical Sciences. The EMEP experience confirmed that health is an excellent instrument for international engagement and demonstrated that in the face of tense political relationships, science and medicine can help bridge divides where politicians cannot.

Endnotes


