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## Prospects for Clinical Research†

G. Donald Whedon, MD\*

One of the principal reasons I have been invited to speak here at Henry Ford Hospital is my very long friendship with Richmond Smith. Rich and I go back to the 1940s when we were research fellows (along with George Hamwi, Bill Thomas, and Anne Carter) in Ephraim Shorr's Endocrinology Division of the New York Hospital-Cornell Medical Center. The quality and effectiveness of Dr. Smith's hard work in endocrinology and in internal medicine have been well known over the years far beyond Detroit. Through all the years that he has been here and I have been in Bethesda, the close friendship of our early fellowship days has persisted. There is something very special about early friends; these are not only the longest of friendships, but also the closest and best.

I hope it will interest staff members of one of the greatest clinical care establishments in the world to hear from us in the National Institutes of Health (NIH), the institution which supports with federal funds two thirds of medical research in the U.S., some perspectives on support of medical research and education. The association of medical research, education, and clinical care is probably far closer than any of us realize, but the quality of clinical care, and probably its quantity, are inevitably dependent upon the quality and quantity of the development of new biomedical knowledge, the training of young physicians, and the continual updating of their skills. From all that I have seen and heard, particularly over the past few years, Henry Ford Hospital fully understands and lives by the close interrelationship of these three cardinal elements of medicine.

In addressing the question, "What is the future of support for medical research and education?" we recently examined all the NIH data we could on research grants and training. The history of research grant funding from 1950,

the year by which a considerable number of Institutes had been founded and extramural programs had begun, showed slow early beginnings and then a rapid growth during the late 1950s and early 1960s. NIH support of research increased steadily until the final years of the Johnson Administration; then there was level funding over the next six years and even an impoundment of funds in 1973; then "escape" during the Ford Administration. It seems particularly appropriate for me to mention *here* one of the very beneficial influences of the Ford Administration. The "escape" varied from Institute to Institute but was greatest for the National Cancer Institute (NCI) and the National Heart, Lung, and Blood Institute (NHLBI), particularly from 1973-76. The budget of the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD) began to grow again during 1976-79, due mainly to phenomenal public and Congressional interest in diabetes. Increased *funding* in recent years, of course, has meant recovery, but a better physical sign for diagnosis of the state of health of medical research has been the increase in numbers of research grant *applications*, particularly during the past two years, an indication of the vitality of interest in research among investigators in universities and medical centers.

Despite this reasonably healthy state at present, as indicated by funding and numbers of applications, leaders of medical societies have recently expressed considerable concern for the future of research and particularly of clinical research. The pertinent NIH data show that although the actual number of MD investigators has held level over the past half dozen years, the proportion of MDs among principal investigators on research grants has declined, due to the considerable increase in the number of PhDs as principal investigators. We feel some reassurance from the fact that MDs are scoring as well as PhDs in reviews of their grant proposals and in the proportion of awards to the number of applications. The data reviewed, however, show disturbing portents for the future of training grants and fellowships. Since 1974, the number of MDs receiving research fellowships has steadily dropped. My concern for the future of clinical research is increased by the knowledge that this drop in MD fellowships and traineeships is

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not due to a decrease in training funds, since fully one fourth of the available training and fellowship slots have not been filled.

There are probably several reasons for declining interest in research on the part of medical students and residents.

- 1) Predominant interest in delivery of medical care.
- 2) An accompanying belief that society is more approving of the good physician than of the professor/investigator.
- 3) Uncertainty as to the continuity or long-term stability of support for research from the largest source of support, the federal government (which I believe is an exaggerated and unsound reason).
- 4) Revision in medical school curricula so that exposure to laboratory techniques has been limited.
- 5) Recent changes in specialty board requirements and increased interest in sub-specialty certification. After graduation a longer time is spent in clinical diagnostic and care experience, and the opportunity to enter research is long delayed. Growing economic pressures to go into practice are extremely difficult to resist.
- 6) Economic pressure per se.

The NIH has already begun to respond to this situation in several ways, particularly in the form of new or unusual means of support for those interested in research careers. These include so-called Young Investigator awards and, in NIAMDD, a Clinical Investigator award program for individuals with four to seven years' postdoctoral experience. In the field of diabetes we have just initiated a Special Emphasis Research Career Award (SERCA) and a New Investigator Research Award. Depending on our experience in diabetes, we probably could extend these two new research exposure and "training" activities to other program areas.

Among other actions which the NIH will be taking, as of July 1, 1980, is an increase in stipend levels for fellowships and traineeships. Now being issued are announcements of a revival of the "short-term training" program which will take advantage of a revision the Congress made in the National Research Service Act in fall of 1978. The revision in this Act, which authorizes legislation for training, exempts from payback training periods of from two weeks up to three months. "Non-payback training" of up to three months should provide an opportunity to begin to instill research principles into receptive students and might weigh positively in the balance of a career choice. The requirement for "specialized intensive training courses," we think, can be satisfied by having groups of trainees from a number of training programs in the same school attend a systematized series of seminars on research methodology, technology, biostatistics, etc.

The resources of government support, however, can do only so much. There must be an intrinsic or endogenous re-awakening of interest in research, starting at the medical student level in the medical schools. Equally important, the great hospitals have an important role to play. Not only do they provide the best care for patients but, like Henry Ford Hospital, they are the major educational institutions for postgraduate clinical training and experience, which takes place through the residency and young physician levels. Henry Ford Hospital is so renowned for quality of care that its contributions to the development of a "better product" for the consumer patient are not fully appreciated, especially locally. For many, many years at a low and quiet level, the Edsel Ford Institute for Medical Research put out very sound research by men well known in their respective fields. For many years, the clinicians, superbly trained, were providing advances in clinical knowledge by their astute observational powers, which were then communicated to the medical community at large through many publications in many journals.

But now, Ford Hospital has just entered a new and potentially very great phase. Through the support of the Ford Foundation, with the building of the Benson Ford Education and Research Center, and the commitment of the administration, all led by Richmond Smith, you are now putting into action a superb demonstration of the interdependence and inseparability of new knowledge produced by research, of medical education and clinical training, and of quality care of patients. In this remarkable new setting, the medical staff has the chance to lend a forceful hand to the renaissance of clinical investigation we surely need nationally.

I urge the medical staff here to have a stronger feeling of their role, of their special opportunity, and of their responsibility, to do more in clinical research. Furthermore, renew your efforts to infuse residents and affiliated medical students with a spirit of enjoyment, even excitement, in observing, in measuring, in planning clinical experiments, and in finding new facts and correlations that may give clues to practical, positive influences on disease, the treatment of which is so much in the minds of medical students and residents today.

This brief message, accenting the undergirding importance of research to clinical care, is not new to you, except perhaps as a call for help in bringing about a recovery of clinical investigation. You have heard this message from Richmond Smith over all the years of his service to this renowned institution. I simply urge you to hear him again, or hear him still, and to continue the fine performance you have made over the years under his leadership.