Guest Editorial

Research in Family Medicine and the Department of Health, Education, and Welfare

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During the last eight years, satisfaction with the phenomenal growth in the numbers of educational programs in family medicine has been tempered by suggestions from leading educational authorities, such as Geyman,[1] McWhinney,[2] Kane,[3] and Mayo,[4] that the discipline must achieve academic validity to survive. All these authorities agree that the term "academic validity" includes, in addition to educational rigor and validity, a research capability which produces new knowledge on health and disease as it exists and evolves in the workday world.

Most family medicine educators and many practicing family physicians accept this thesis and *The Journal of Family Practice* has provided strong leadership and support in its editorial and feature columns.[5,6] Yet in spite of this, research in family medicine often appears to our colleagues in other disciplines to be capable only of descriptive studies. This is a disturbing conclusion and warrants an examination of the factors which might have prevented or delayed the development of intervention studies in the field of primary care.

The goal of any research is to improve the care of people. Primary care, and particularly family medicine, deals with people in the social unit of the family living in communities. Thus, research in primary care and family medicine must be involved in the social context and must be problem centered, person and family oriented, and population based. However, research is expensive. It uses technological, fiscal, and human resources to a prodigal degree. This is well recognized in academic circles and also by the Department of Health, Education, and Welfare, which currently funds the National Institutes of Health to the tune of about $2 billion a year,[7] most of which goes to fundamental and clinical research.

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Primary care and family medicine researchers who seek support for their work must seek funds from the same Department of Health, Education, and Welfare resources as their colleagues in other specialties and subspecialty disciplines.

There are several significant factors involved in this approach.

1. As a nation we are established in an inflationary cycle.

2. It is impossible to fund every research interest. Priorities must be set by some authority.

3. Congress is seeking better ways of translating the results of basic and clinical research into improved care for persons in the community. This interest shows in the writing of laws which contain increasingly specific programmatic requirements.[8]

4. A long standing, well-established, and extremely effective peer review system for determining the quality of research proposals exists in the National Institutes of Health. This system is effective but tends to be innately rigid and overinfluenced by traditional approaches.

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The first two statements are self-evident and require no further discussion. Statements 3 and 4, however, require further examination. Statement 3 represents a trend which has developed over the past four or five years, resulting from Congressional attempts to influence physicians to improve the care of patients with the diseases of aging and degeneration such as cancer, diabetes mellitus, and stroke. These Congressional initiatives have resulted in the development of Cancer Centers, Stroke Centers, and Diabetes Research and Training Centers. All include in their design, methods of enabling the translation of bench and hospital-based clinical research in their fields into the improved care of patients with these problems in community settings.

This would seem to be a fertile field for innovative associations between university specialty and subspecialty departments in those areas and departments of family medicine which have strong links in the community, thereby building bridges between the university and the community. Although this approach has been tried, as yet no program has been successful.

Many reasons can be given for this lack of success but among them we must question the effectiveness of the NIH peer review system in determining the quality of such proposals.

Statement 4 identifies some of these concerns. The review system in the National Institutes of Health consists of two levels. First, that of peer review by site visit teams selected by the project staff. Secondly, final approval by a council or a group of regents at each division level of NIH.

This system does a superb job of assessing the scientific validity of new work in established areas of interest. It is perhaps less capable of addressing the validity of a new conceptual approach.

Site visit teams tend to be selected from the highly specialized research field. They are, without exception, extremely competent and knowledgeable in their own particular field of interest but often have less knowledge or understanding of the demands of clinical community practice, which represents a functional environment different from their own experience. Further, the current "state of the art" of research in primary care does not match, in scientific validity and reliability, that achieved over several generations of specialty and subspecialty research in hospital and laboratories. Rarely is this fact either understood or accepted by site visit teams.

Peer review teams have a democratic structure and the decision to approve or disapprove a project is based on a simple majority vote.

It is obvious from the above that the primary care researcher seeking NIH funds is faced, not only with the challenge of developing a scientifically valid and reliable study in his subject of interest, but also the lottery of having it reviewed and assessed by colleagues who may have the same topic of interest but function in a different field of endeavor.

The above represents a somewhat gloomy appraisal and yet recently there have been signs that a change is on the way.

Two major developments have occurred recently which presage a different scenario during the next 5 to 10 years.

On October 3-4, 1978, at the National Institutes of Health, Bethesda, Maryland, was held a National Conference on Health Research Principles. The conference was organized by Dr. D. S. Frederickson, Director of the National Institutes of Health at the request of Secretary Califano.[9]

Five panels of experts drawn from federal departments and agencies and from the public sector were arraigned to hear testimony from witnesses from the scientific community relating to:

1. Fundamental Research
2. Clinical Applications and Health Services Research
3. Health Regulation and Promotion
4. Research Capability
5. Unifying Concepts

Family medicine was represented by a team of witnesses drawn from the membership of the Society of Teachers of Family Medicine and the North American Primary Care Research Group, which presented testimony to each of the five panels.

A draft conference report will be evaluated by the Institute of Medicine of the National Academy of Sciences and then sent to the conference participants for review and comments. The objective is to produce, by the fall of 1979, a five-year plan for the proportionate distribution of NIH funds by division, section, and program.

It is perhaps not too optimistic to hope that an increased proportion of NIH funds will be directed towards person and family-centered and population-based research. In any event, this con-

ference represents a significantly different level of involvement of the political establishment in the health research field from what has pertained previously.

The second major development reinforces the above statement in a very specific way. On October 24th at the American Association of Medical Colleges in New Orleans, Secretary Califano addressed about 3,000 medical educators. He stated that health care is now the nation's third largest industry. In FY1978 it accounted for $180 billion expenditure and involved six percent of the US work force. The latest estimates are that by the year 2000 the health care industry will account for $1 trillion or 12 percent of the gross national product.[10] Secretary Califano stated that such facts and projections "make it essential and natural that a substantial measure of partnership exists between the profession and the nation's government." Mr. Califano provided four fundamental tenets of national policy for the next two decades.

1. The nation faces an oversupply of doctors.

2. Too many specialists and subspecialists are being produced with a consequent reduction in the proportion of primary care physicians, causing the entire health care delivery system to be unnecessarily skewed towards the most expensive specialty end of the spectrum.

3. There is a serious geographic maldistribution of doctors.

4. Medical schools must take a more active role in making physicians responsive to the demographic, social, and economic changes which have deep implications for health care.

In tenet 4, Secretary Califano mentioned the need for more emphasis on chronic conditions, more attention to palliative and rehabilitative medicine, and more need for long-term care and the care of emotional and mental problems. He raised the issue of the lack of understanding by physicians of the costs of their services and the costs they generate by their clinical decisions. He indicated that the administration would take at least the following steps.

1. To review reimbursement formally so as not to discourage ambulatory care.

2. To institute programs of support for departments of family medicine and other primary care disciplines.

3. To support more residencies in primary care fields and investigate the problems of providing other incentives to encourage primary care.

Later, he stressed that prevention must be built into the health care system by using the preventive disciplines, such as epidemiology and nutrition.

His final remarks included the statement that the administration was "working to establish a multi-year strategy to put federal support of research on a stable, dependable basis, which process would involve public policy as well as scientific judgments."

What does this mean to the researcher in primary care or family medicine?

A hope that for the first time fiscal resources will be made available to expand "the state of the art" in family medicine research. This would take it from the first stage of baseline measures and descriptive studies to the second stage of controlled intervention studies, problem oriented, person and family centered, and population based.

A hope that the present organization of the DHEW research establishment will allow this to occur within the next two years.

A hope that if it does not occur during that time a new initiative within National Institutes of Health such as a National Institute of Primary Care Research or an expansion of the role of the National Center for Health Services Research will provide the necessary resources and support.

If these hopes are fulfilled, academic family medicine will have moved from childhood into adolescence with the promise of an early maturity ahead.

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