

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

BETHESDA, MD. 20014



NATIONAL INSTITUTES OF HEALTH
Area Code 301 Tel: 656-4000

AUG 18 1965

Dear John:

I am pleased to respond to your letter which requests our advice on several matters raised at your meeting in Chicago. I apologize for the long delay in answering your letter, but our staff has been overloaded this summer. I will discuss the items in the order in which you listed them in your letter.

1. DeBakey Report - Manpower.

A medical manpower problem does exist. This has been recognized by the Congress in the passage of the Health Professions Educational Assistance Act. That program has as its primary focus the production of increased numbers of physicians with the essential medical training leading to the M.D. degree. But the basic production of more physicians is only part of the answer to the manpower problem. The training process of the physician does not end with the M.D. degree, especially in this age of the rapid advance of knowledge. We need more effective means for continuing education of present medical manpower, and for the training of highly skilled medical specialists. We also need to insure the most effective use of our existing pool of medical manpower.

The medical complexes program will provide important assistance in solving those aspects of the medical manpower problem beyond the production of more physicians. Within the regionally coordinated framework of the complex will be provided the environment and the means for many types of effective continuing education programs and for the development of new and creative methods to carry the benefits of scientific progress to the local practicing physician. By making the latest advances in diagnosis and treatment more widely available under carefully conceived regional plans, existing medical manpower can be more effectively utilized. Better specialty training can be made more widely available so that the medical manpower already engaged in the treatment of the complex problems presented by heart disease, cancer, and stroke can be afforded better opportunities to be trained in the latest techniques produced by medical science.

The need for more physicians will continue to exist, and the legislation to improve and extend the Health Professions Educational Assistance Act

will help to accelerate the output of M.D.'s. But the medical complexes program will serve as a vital complement to the educational programs of our medical schools. The manpower problem, correctly conceived as broader than the production of numbers of physicians, can only be fully met through both efforts operating simultaneously.

Since the bill provides for careful planning of a medical complex on the regional level, we would expect the plans to provide for the orderly development of the complex consistent with the availability of trained manpower. The ultimate goal of fully developed complexes in all regions is a long-range goal that should be completely consistent with the long-range intention of our Nation to have available an adequate supply of medical manpower.

2. More research on human beings.

As you know, the National Institutes of Health has a long history of encouraging high-quality clinical research which is effectively linked to advances in the basic biomedical sciences. The opening of the NIH Clinical Center in 1953 marked a great step forward in the concept of a clinical research facility which integrated clinical and laboratory research. Since 1960, the NIH has stimulated clinical research in medical centers all over the country through the General Clinical Research Centers grant program. At the present time, there are 84 of these clinical research centers being supported by the NIH. These centers reproduce on a smaller scale the type of clinical research environment that has made the NIH Clinical Center so valuable.

The benefits of a General Clinical Research Center can be summarized as: (1) providing a suitable setting for individual clinical investigators; (2) creating a cohesive force for clinical investigation by which a variety of competent and qualified investigators may collaborate on a single problem; (3) encouraging interdisciplinary research by providing a resource where research ideas from different investigators may be dispersed; (4) offering basic scientists maximum opportunities to participate in clinical research; (5) improving the physical environment of otherwise poor clinical research resources in many medical schools; (6) affording a model of excellence for clinical research and clinical research training; (7) providing a stable, long-term source of bed support; and (8) providing an isolated facility with trained personnel for precise data collection. Establishment of these centers has served to enhance the quality and quantity of clinical investigation.

3. Clinical Pharmacology

We do not believe that clinical pharmacology can be separated as a discrete scientific discipline. The problem is to create an environment that permits clinical studies against a backdrop of basic laboratory research. Two years ago we presented the need for pharmacology-toxicology centers which would provide such an environment within the university context. In my view there has been too much of a tendency to isolate pharmacology from the other basic disciplines which are highly relevant to the study of the interaction of exogenous agents and biological systems. Until our basic understanding of these processes is improved, we cannot expect significant advances against the problems of adverse drug reactions, prediction of drug efficacy, environmental pollutants, and all of the other problems, the solution of which depends on our knowledge in the fields of pharmacology-toxicology.

Matter of using up money near the end of the fiscal year.

As you know from your long experience with NIH appropriations, we do not use up money near the end of the fiscal year in a manner inconsistent with the effective and efficient use of the funds. The bulk of NIH funds are expended through grants which are carefully reviewed by outside advisory groups. Our dual review system insures the high quality of the activities supported by these funds.

You may have specific reference to the special award of general research support grants near the end of fiscal year 1965. You are aware that the obligation of these funds was delayed by a policy difference within the Executive Branch and the decision to award these supplementary grants was made in lieu of a final determination concerning the award of general research support grants to the non-health related programs of the universities.

5. Objection to the idea of Categorical Centers.

I believe that the history of the NIH programs is ample evidence that research funds can be effectively utilized under a categorical approach in a manner that does not inhibit the support of sound basic research in the broad spectrum of sciences related to health. Apart from the NIH experience, some of the categorically oriented centers around the country have outstanding records of productive research. Such centers often provide the setting for an effective interrelationship between fundamental laboratory research and clinically oriented research. As long as the basic biomedical sciences and the training of broadly based research scientists are adequately supported, the categorical centers constitute a valuable component of our total biomedical research effort.

John: much of the balance in report year is covered by a highly complex and very rigid appropriation. This is not a complaint but a statement of fact.

I hope that I have been able to provide you with some useful assistance on these important matters.

My kind regards.

Sincerely yours,



Director

Honorable John E. Fogarty
House of Representatives
Washington, D. C. 20515

P. S. I thought I should add my side note on page 3 as a more legible postscript: Much of the balances in recent years is covered by a highly complex and very rigid appropriation. This is not a complaint but a statement of fact. J.