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Aiming Low

Advice to residents considering a research project

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I RECENTLY JOINED MY colleagues in an evening meeting with neurology residents. The objective was to share our research interests. In part this was to let them know what we were doing, thus completing their picture of us, expanding it beyond the teaching and clinical care arenas. This is one



area that partly distinguishes medical school faculty and private practitioners, although more about this later. The other objective was to try to excite an interest in some residents to try their hands at research and for them to find out if they might be as excited by doing this sort of work as the faculty are.

My colleagues were very good about describing their work. There were six minutes allotted for each of us and they kept to it. They were succinct and positive. Some participated in large clinical trials. Some used sophisticated equipment. All, most importantly, were enthusiastic about their work. I was, as well. I mentioned the unfunded projects I was about to embark on, using college student volunteers, and some projects that were being completed by a resident, as well as one that was started and never completed by another resident. I finished in less than six minutes and was asked what advice I had for resident research. This is where I got into trouble.

I am an enthusiastic researcher. Every day there are either questions raised that need to be answered, or the same question asked day after day that no one has yet answered. I want others to do research. I sometimes wonder how the vast bulk of doctors do their work, seeing patients from morning to night, day after day, and not getting pulled in to answer the many questions that must enter their minds every day. But, I've learned many lessons in my lengthy career. One of them is that I'm considered opinionated. Not unreasonable, I don't think. Not irrational or dogmatic, just strongly skeptical. Another is that clinical research takes a lot longer than anyone would think possible in a universe where light travels at 186,000 miles per second. I made two points to the residents. One was that everything took at least four times longer than you could conservatively and reasonably estimate; that if you wanted to do a project at two hospitals in the Brown system to not waste your time trying because getting approval from two institutional review boards during one residency would be sufficiently unlikely that the project would never be completed. I explained the KISS principle of research: Keep It Simple, Stupid. Novices believe that once you start a project you should

try to gather as much data as possible since the incremental effort is always small. That slippery slope, of adding a test here and a measurement there, is often the cemetery of "doable" projects. Finally I recommended, "Aim low."

After I said this I realized that it might have been a faux pas. After all, these were doctors. They were all pretty smart, all very hard working, dedicated and high achievers. Had they ever in their lives heard anything after the word, "aim," but "high?" I think I should have said, "aim for low hanging fruit." That's a common phrase that we use when we talk about projects that will have long-term, sometimes difficult to achieve ends, but may, in the beginning, produce some interesting and useful results, easy to harvest. For example, I'm interested in the problem of fatigue in Parkinson's disease. I got interested because of one particular patient in whom fatigue was his main problem and when I turned to the literature on fatigue in PD I found that there was none. It was not known to be a problem. The "low hanging fruit" was to find out how common and severe a problem it was, whether it was related to disease severity, depression, age, gender, duration of disease, medication side effects, sleepiness, etc. Anyone can do that. The harder part is figuring out what causes it and how to treat it. Twenty years later we have a large number of papers describing the epidemiology of fatigue in PD around the world, three on its treatment and none on its causes.

The higher hanging fruit are not so easy to harvest. Residents and students need to aim for the low hanging fruit so that they can get the job done in their limited amount of time. Another issue related to time is the fact that time passes much more quickly for old people than young. A project that takes two years may be fine for an older researcher who is used to events unfolding slowly, hoping he'll get the result while he still can understand it, but a young researcher needs a faster reward to maintain interest. Short, easily attainable projects are the goal.

Research of all types should be fun, although a lot more satisfying when the results are what we want. Medical practice is, for most of us, rewarding for a number of reasons, helping sick people, helping families, preventing illnesses, getting to know patients and families over long time periods. We all learn from our patients, whether we're

aware of it or not. We learn when to take a complaint seriously and when reassurance rather than an expensive test is in order. We learn humility. We are not gods and cannot make most bad things go away. Patients can be intellectual challenges as well. While we are not generally faced with challenges like Dr. House on television, we all have our share of unexplained problems that nag at our thought centers. Clinical research aims at solving those problems. Studying the problem hones our skills and keeps us sharp. And you don't necessarily need a university title or funding to do it. We rely on clinical researchers to turn experience-based medicine into evidence-based medicine.

It's always better to learn something, even if not earthshaking, than to have to give up an unrealistic quest. So when you start a research project, I suggest that you aim low. ❖

Author

Joseph H. Friedman, MD, is Editor-in-chief of the *Rhode Island Medical Journal*, Professor and the Chief of the Division of Movement Disorders, Department of Neurology at the Alpert Medical School of Brown University, chief of Butler Hospital's Movement Disorders Program and first recipient of the Stanley Aronson Chair in Neurodegenerative Disorders.

Disclosures on website

Rhode Island Medical Journal Submissions

The Rhode Island Medical Journal is a peer-reviewed, electronic, monthly publication, owned and published by the Rhode Island Medical Society for more than a century and a half. It is indexed in PubMed within 48 hours of publication. The authors or articles must be Rhode Island-based. Editors welcome submissions in the following categories:

CONTRIBUTIONS

Contributions report on an issue of interest to clinicians in Rhode Island. Topics include original research, treatment options, literature reviews, collaborative studies and case reports. Maximum length: 2000 words and 20 references.

JPEGs (300 ppi) of photographs, charts and figures may accompany the case, and must be submitted in a separate document from the text. Color images preferred.

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ADVANCES IN LABORATORY MEDICINE

Authors discuss a new laboratory technique. Maximum length: 1000 words.

IMAGES IN MEDICINE

Authors submit an interesting image or series of images (up to 4), with an explanation of no more than 500 words, not including legends for the images.

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A Refuge for the Medical Student, the Dissident and the Pilgrim

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THE ROMANS CONSTRUCTED a fort overlooking the Rhine River's entrance into the North Sea. The Celts then established a small settlement on the hill, called it Lughdunum, later corrupted to Leithen. By the 10th Century, Leithen, now called Leyden, had grown to be a prosperous trading center specializing in textiles.



In 1574 Leyden was besieged by Spain attempting to suppress the Protestant insurgency. The lengthy siege was broken when the Dutch breached their dikes flooding the countryside and thus allowing ships to bring in food.

A year later William of Orange established a university in Leyden to commemorate the valiant struggles of the community. The academic center, based at the Convent of Saint Barbara, tolerated, even encouraged, departures from orthodox religious belief; and so, from its modest parochial origins as a retreat for religious studies, it evolved into an international center for the scholarly disciplines of law, exotic languages, ethnology, botanical science and, in 1597, medicine.

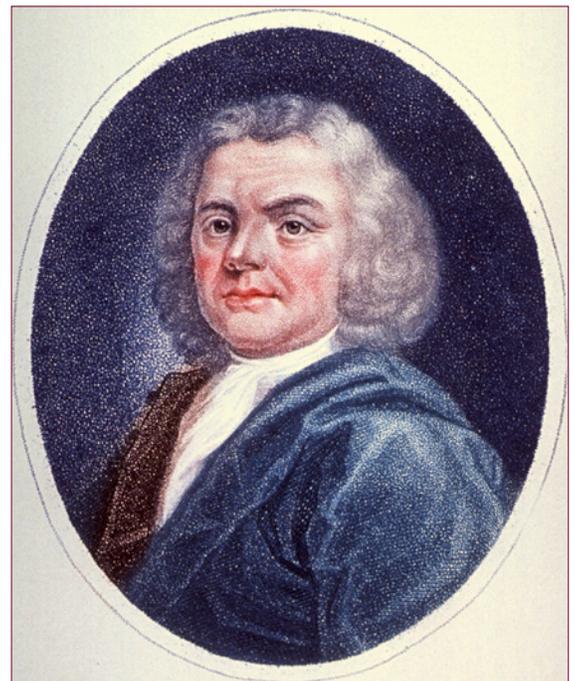
Preeminent amongst its medical faculty was the immortal Herman Boerhaave (1668–1738) considered to be the father of modern bedside medicine. Boerhaave was born in Voorhout, neighboring upon Leyden. Boerhaave's

method of bedside clinical examination, by the 18th Century, became the criterion of acceptable medical practice. Many European nations sent their most promising students to be taught in Leyden; and even Russia's tsar Peter the Great, went personally to listen to Boerhaave's lecture.

In 1655, Dr. Francis de la Boe, called by history Franciscus Sylvius, joined Leyden's medical faculty. Sylvius stressed the importance of proper nutrition, adequate rest, and a stress-free lifestyle in the restoration of those with chronic, debilitating disease. He sought out botanically derived preparations that might stimulate the flagging appetites of his anorectic patients. His search finally centered upon the berries of the juniper bush (in Dutch, *genever*). He dissolved the berry juice in warm alcohol to form a decoction with an alleged capacity to enhance appetite. The name of this preparation, which achieved astonishing popularity amongst the Dutch, was *genever schnapps*, a designation corrupted by the British to the word, gin.

Scotland was compelled to develop its own schools of medicine in the 16th and 17th Century when England's medical schools, Cambridge and Oxford, required their matriculants to sign oaths adhering to the rules of the Church of England, thus excluding nonconformist Christian groups such as the Quakers.

Edinburgh's inaugural faculty-physicians were all trained in Leyden and Boerhaave became the spiritual father of Scotland's four medical schools: Edinburgh, Glasgow, Aberdeen and St. Andrews. Edinburgh, in turn, educated the bulk of the medical education leadership in colonial America including the founders of this nation's first medical



Portrait of Dutch physician Herman Boerhaave, MD, by artist J. Chapman

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Portrait of Dr. Francis de la Boe, who concocted the 'herbal' remedy of juniper berries mixed in alcohol (gin), by painter Cornelis van Dalen.

schools and teachers such as Benjamin Rush and Benjamin Waterhouse. Thus, if Edinburgh had been father to America's system of medical education, then surely Leyden was its grandfather.

The Pilgrims

The principal role of Leyden in American history, however, rests upon another happening. In the early decades of the 17th Century England had undergone much religious turmoil. A group of Dissenters from the village of Scrooby abandoned their ancestral homes and fled to Leyden. And for eleven years these religious dissidents found refuge in this city of textiles. In 1620 they resolved to find a new place to practice their faith. Their ship, called Mayflower, left Europe on September 6, 1620 and sailed west to the Americas. In the words of William Bradford, their leader, "In our hearts we knew that we were pilgrimes." And by the name, pilgrims, was this group henceforth known.

An astonishing little city: Leiden (as it is now spelled) was the focal point in the Netherlander rebellion against Spanish tyranny; the location of an intellectually permissive university; a haven of scholars and the site

of a medical school without religious requirements; the center of experimental and bedside medicine, the academic seeds of which spread to Edinburgh and then to England's Atlantic colonies; the site where a great botanical garden was established and where Linneaus developed the science of taxonomy; the city where gin was invented; the birthplace of Rembrandt; and the refuge and organizational center for those remarkable men and women, the Pilgrims, who had ventured west to the wilderness of New England in search of a new Jerusalem. "And thus," in Bradford's words, "out of small beginnings greater things have been produced by His hand that made all things of nothing." ❖

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Stanley M. Aronson, MD, is Editor emeritus of the *Rhode Island Medical Journal* and dean emeritus of the Warren Alpert Medical School of Brown University.

Disclosures

The author has no financial interests to disclose.

Guidelines for Letters to the Editor

Letters to the Editor are considered for publication (subject to editing and peer review) provided they do not contain material that has been submitted or published elsewhere.

The *Rhode Island Medical Journal* prefers to publish letters that objectively comment on or critically assess previously published articles, offer scholarly opinion or commentary on journal content, or include important announcements or other information relevant to the Journal's readers.

Letters in reference to a Journal article must not exceed 175

words (excluding references), and must be received within four weeks after publication of the article. Letters not related to a Journal article must not exceed 400 words (excluding references).

A letter can have no more than five references and one figure or table. A letter can be signed by no more than three authors. The principal author will be asked to include a full address, telephone number, fax number, and e-mail address. Financial associations or other possible conflicts of interest must be disclosed.



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Thanks to our guest editors

We would like to thank our many guest editors for producing the themed issues we've published this year. Many of the readers probably have no idea how issues come to be. Most issues have a theme. In some cases, a member of the medical community steps forward and offers to guest edit an issue of the journal, devoted to a topic of interest to that person, and, presumably, to a large percentage of the membership of the RI Medical Society (RIMS), which sponsors this journal. The guest editors are responsible for choosing topics and finding authors within the RI medical community. The hard part of their job is getting the authors to actually complete their manuscripts, which the guest editor then edits and makes publication ready. My job, as editor-in-chief, is to make sure primarily that our average member will understand the writing, since RIMS is comprised of physicians from all branches of medicine; and also, that the articles are not duplicative and are at a certain level of sophistication and literary quality. The sophistication threshold is, if this neurologist can understand it, then probably everyone else can as well. Not all the editors stepped forward with an idea of their own. Our staff approached some. Few doctors have declined to help the journal, although this is a time consuming and sometimes aggravating venture.

The mission of the journal is to advance medicine in the state of Rhode Island. We are not interested in becoming a national journal with an impact factor. We would like to have a high impact factor in RI, but don't care about our impact elsewhere. We particularly like to see articles specifically focused on RI issues, and view our journal as a stepping stone for junior members of the medical community, house staff, fellows, students, and junior faculty to hone their skills writing medical articles, whetting their appetite for achievement by starting with early publications. In the coming year we will have an issue devoted to medical student research, and another on long-term care and nursing homes in RI. We've had issues on biotech in RI, and a variety of other topics grounded in our state. We intend to keep that focus.

We have been very fortunate. We believe our contributors have done extremely well and we wish to thank them. We are grateful. We are proud of the journal, and that is because of the high quality work of our guest editors, contributors, our two outstanding staff members, Mary Korr and Marianne Migliori, and the support of our associate editor, Sun Ho Ahn, MD.

Readers who would like to see a particular topic addressed are welcome to offer themselves as a guest editor, or to simply contact me with their idea. Chances are that if there's a topic you want to see in the journal, a lot of others would like to see it as well.

Thank you all.

Best wishes for the New Year.

Joseph H. Friedman, MD

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