Letter from the Editors
Dylan Nielson, The Ohio State University College of Medicine
Mohamed Ahmed, Syracuse University

This fall issue of Phi Psi is the first to be released by the 2012 Public Relations committee, and we have some exciting changes to tell you about. With the launch of our new website in November, we will be bringing you new articles once a week and, in a new program, helping APSA members share their research. We know you want to tell your colleagues about your work, and we want to help. Send us a short description of a paper you have recently published and we will post it on APSA’s homepage. The best of these short write-ups will be awarded $100 and recognized at APSA’s Annual Meeting.

We begin this issue of Phi Psi with a letter from APSA’s President, Dania Daye, welcoming you all to the regional meeting and describing the exciting year that APSA has planned. She announces our new website and new programs, such as APSA Interest Groups. Dania also gives an update on the Policy committee’s ongoing mission to generate high-quality data on the needs of physician-scientists to support our advocacy efforts.

We have two articles in our new series, Considering Careers, exploring the viability of different specialties for physician-scientists. Alex Adami considers physical medicine and rehabilitation, describing the availability of research residencies and focusing on research areas that would best complement PM&R. As his article explains, if you are interested in neuroscience, robotics, or engineering, PM&R is worth considering. Yun “Rose” Li brings a more personal perspective to her article on surgical specialties. She discusses the challenges trainees in this area face and her motivation for pursuing this path.

John Frater brings us a report on the newly created Office of Emergency Care Research at the NIH. To help understand the impact of this new office, John spoke with Dr. Jill Baren, a former president of the Society for Academic Emergency Medicine. The OECR and the impetus to facilitate research in emergency medicine represent great opportunities for physician-scientists. Trainees in particular could benefit as one of the OECR’s goals is to attract more aspiring physician-scientists to emergency medicine.

In his second article for this issue, Alex examines the potential impact of sequestration on US scientific funding. He also explores what the future may hold for funding even if the “fiscal cliff” is avoided. His article discusses in stark terms the current climate for scientific funding and has advice for what we can do to improve the situation.

Thank you again for reading the APSA newsletter and please contact us if you have any comments or ideas. You can reach Dylan Nielson at Dylan.Nielson@physicianscientists.org. You can also keep up with APSA news on Facebook, Twitter (@A_P_S_A), and LinkedIn.
From the President
Dania Daye, Perelman School of Medicine at the University of Pennsylvania

Dear Friends and Colleagues,

It is my pleasure to welcome you to this APSA Regional Meeting. We are very excited about all of our meetings throughout the country this year and have been able to assemble an excellent line-up of speakers and small-group moderators this season, with new topics for discussion that we have never before explored.

We are also thrilled to announce our many new initiatives for the 2012-2013 year. First, APSA will be launching a brand new website in mid-November, which will improve the functionality of our current website and will transform the way in which members communicate, through forums, blogs, personal messaging, and a multitude of social media features. In addition, with this website, we will launch our APSA Interest Groups, which will allow APSA members to seek advice and learn from expert mentors in their particular field of interest, starting with Emergency Medicine, Hematology-Oncology, Infectious Disease, and Neurology. The new site will also feature specialized pages devoted to member research and achievements with prizes awarded to participating members with the best entries.

During this year, we are also focused on expanding our membership and offering improved benefits to our current APSA members. In particular, we are focused on engagement and recruitment of undergraduate and resident and fellow members. We want to involve those training as a physician-scientist at the earliest stage and continue to retain those members throughout their training so that they can educate and mentor the next generation of physician-scientists. We will be holding small-group sessions and focus groups throughout the year to determine what APSA can do for its members and how to improve the benefits that members currently enjoy. New benefits that will already be offered this year include research day prizes for students, sponsorships of local chapter events, and more travel awards to our 9th APSA Annual Meeting in Chicago, IL.

Our Policy Committee has also been working to publish results and develop data-driven policy recommendations from a number of initiatives examining issues affecting your career development as physician-scientist trainees. Among our ongoing initiatives is a survey regarding the NIH’s F30 program and the Tomorrow’s Physician-Scientist Survey, which examines the perspectives and projected obstacles of thousands of medical students and physician-scientists-in-training across the country. Preliminary results from these initiatives will be presented at a number of national meetings this year that include the 2012 AAMC annual meeting, the 2012 ASHE annual conference, as well as the 2012 AMA interim meeting. Stay tuned for more information regarding the publication of these results.

We look forward to working with you this year and to all of APSA’s exciting new initiatives that will transform the organization. Thank you again for your support, and please e-mail me at dania.daye@physicianscientists.org and let me know if there is anything that I can do for you.

Sincerely,

Dania Daye, Perelman School of Medicine at the University of Pennsylvania

How the Office of Emergency Care Research Will Help Trainees
John Frater, The Ohio State University College of Medicine

With the recent announcement of the new Office of Emergency Care Research (OECR) at the NIH, a distinct niche has opened up in the realm of Emergency Medicine ideally tailored to physician-scientists. Although the NIH had previously established an Emergency Care Research Working Group, the foundation of the OECR displays a new, stronger commitment to basic, translational, and clinical research applicable to the emergency care setting.

In a recent press release issued by both the American College of Emergency Physicians (ACEP) and the Society for Academic Emergency Medicine (SAEM), the leaders of both these organizations indicated that they were very pleased with the establishment of OECR, with Dr. David Seaberg, MD, FACEP, and president of ACEP, stating that “this is a landmark event for emergency care research.” An interesting point in that same release is raised by Dr. Craig Newgard, MD, FACEP, PhD, stating both that “This announcement is a boon to emergency care researchers in academia across the country,” and that “the leaders of residency programs and academic departments of emergency medicine will need to identify potential researchers and intensify research efforts.” This brings us to why this new Office is relevant to physician-scientists.

In an interview conducted with Dr. Jill Baren, MD, a former president of SAEM, and an Ex-Officio member of APSA’s board of directors, Dr. Baren shared some of her thoughts about what the OECR

(See Emergency Care on Page 5)
ConsideringsCareers
Exploring Non-Traditional Career Paths for the Physician-Scientist

A Surgical Career for MD/PhDs: Part I
Yun Li, University of Pennsylvania

Choices define and guide the aspiring physician’s journey through medical training, from the choice to seek medical school and to culmination in the choice of specialty. The future physician scientist faces these same choices but with a very different view. While their purely-clinical colleagues select from the entire spectrum of medicine, physician scientists are often reminded that they should stick to the traditional fields, such as pathology and the fellowships following internal medicine, that so many of their forebears entered and prospered in. A brief glance at APSA’s database of research-oriented residencies attests to why, with those and similar fields offering many established and strong programs that blend clinical training with the opportunity for significant research in the field.

What, then, of the physician-scientist trainee who chooses to seek an alternate path? Take physical medicine and rehabilitation (also known as physiatry, or PMR). Recognized as an official medical specialty in 1947, the field has grown dramatically in the last decade, swelling from just over 4,600 diplomates in 1994 to more than 10,600 in 2012. Focused on “diagnosis, evaluation, and management of persons of all ages with physical and/or cognitive impairment and disability,” the growing field cannot escape the attention of at least some physician scientist trainees. However, PMR is a field that must seem to those same trainees so purely clinical that it has no home for them.

While the vast majority of practicing physiatrists are purely or primarily clinical, this does not preclude an interested physician scientist from joining their ranks. On the contrary, the Association of Academic Physiatrists declares the need for research in PMR and actively recruits interested trainees. Together with the NIH, they sponsor a K12 postgraduate training grant, the Rehabilitation Medicine Scientist Training Program, to give physician scientists interested in PMR the opportunity to connect clinic and laboratory. Current students and past graduates of the program encompass the whole range of medical training programs, with MDs, DOs, and MD/PhDs represented. For students currently in the earlier years of medical training, the Association sponsors research experience scholarships to expose interested trainees to the field. Other institutions, including the Harvard-affiliated Spaulding Rehabilitation Network in Boston, MA, offer research-oriented residency programs and research fellowships for trainees and graduates alike. Clearly, opportunities exist for students whose interests lead

(See Surgery on Page 5)

Physical Medicine & Rehabilitation
Alex Adami, University of Connecticut School of Medicine

After a moment of uncomfortable silence, he instructed me, the “young grasshopper MD-PhD student,” on how to respectfully address my seniors. This is especially important for me, he emphasized, because as a MD-PhD I need to know my “betters” in the OR. After all, he notes that my surgical skills will never be up to par compared to a MD-only surgeon. After he felt satisfied that he had crushed my hopes of being a surgeon, he proceeded to methodologically answer my question about his training as an academic surgeon, and his planned fellowship in spine surgery. Then, he told me in words no less clear or crisp than a cold winter’s day that the fact that I even contemplated combining a successful R01-funded research career in cancer biology while practicing in a surgical subspecialty told him that I still was indeed too much of a grasshopper.

Had all my interactions with surgeons followed this manner, I would probably not write this piece or even have contemplated a career in surgery. In fact, my passion for surgery is due to the mentorship of a number of surgical attendings and residents who strongly supported my interest, as a woman, as a MD-PhD student, and a first-year MD in the OR as he and I were left to close after a long 12-hour case. “I mean, what is your planned career path after you finish your residency, that is?” I adjusted my words as he glared at me from beneath his eyewear.

For the rare individual who wishes to navigate a training pathway as a “surgeon-scientist,” it becomes obvious that with 24 hours in a day and colleagues who are every bit as dedicated, talented, and invested, you will either need to limit some aspect of your clinical practice or your research program. Will I always be perceived as somewhat “less” of a surgeon and “less” of a scientist by those colleagues and my superiors? And much more importantly, is such a compromise in time also a compromise of the quality of the work that I will do as a surgeon or a scientist?

In this 5-part series, I will provide insights from current surgeons, physician-scientists, present recent survey and research findings, as well as opinions of current trainees to

(See PM&R on Page 5)
Funding Science: Sequestration and Beyond

Alex Adami, University of Connecticut School of Medicine

One might be forgiven for believing a universal cure for all cancers is easier to find than optimism for the future of science funding in the United States. As the beginning of 2013 approaches, substantial cuts to science funding loom large. With the US government funding a substantial portion of the research done in the US, and by extension the world, the problem of funding science is of enormous importance to all researchers, particularly trainees who will soon be vying for some of that funding themselves or are supported by it now. As you read this, the immediate problem of sequestration (dubbed the "fiscal cliff" by many) may have been resolved. However, recent trends in US science funding suggest that a drastic policy shift is required to solve the long-term issues facing the funding of science in the United States, issues that will remain of critical importance long after today's crisis has passed.

To understand current and future fears for science funding, a brief look at the genesis of the entire debate is necessary. In early 2011, the United States faced an impasse. Government debt levels fast approached a legislative ceiling beyond which there was no path. Facing a government shutdown and a Congress unable to agree on a solution, the Budget Control Act of 2011 was born and ratified in early August of 2011. The act raised the debt ceiling and created the Joint Select Committee on Deficit Reduction to find a solution to the budget crisis. Should that committee fail, the act mandates broad, deep cuts to domestic spending beginning in 2013; sequestration was born. Facing a government shutdown and a Congress adjourned for the election at the end of September, leaving the thorny problem of sequestration to the lame-duck session to follow Election Day.

This brings us to the present. Why are scientists concerned about sequestration? For many months, uncertainty reigned as to the depth and breadth of the cuts. Prodded by Congress, willing to demand details but not willing to correct the problem, the Executive Branch released a comprehensive report on September 14th. The Atlantic and ScienceInsider released analyses of the cuts, and they are sobering for any researcher. NIH funding would be cut by over 8 percent, for a loss of $2.5 billion. The National Science Foundation fares little better, losing $586 million. The research budgets of other departments, including NASA, the EPA, NOAA, and several others, face similar cuts. Even the Department of Defense sees cuts of over 8 percent to its research programs. Table 1 lists the losses to these and other agencies. Further, funds for research represent just one of the cuts that will impact science. Research support programs at the National Institute for Standards and Technology are on the chopping block, while the FDA, which provides important support and resources for drug discovery and development, faces a cut of $319 million from its overall $3.948 billion budget.

The implications of all these cuts are obvious: fewer dollars for drug discovery and development, faces a cut of $319 million from its overall $3.948 billion budget.

Table 1: Proposed Budget Cuts by Program

<table>
<thead>
<tr>
<th>Agency</th>
<th>Total research budget (billions)</th>
<th>Amount to be cut (billions)</th>
<th>Percent to be cut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Defense (All branches)</td>
<td>$91.02</td>
<td>$7.46</td>
<td>8.19%</td>
</tr>
<tr>
<td>NIH</td>
<td>$30.8</td>
<td>$2.5</td>
<td>8.12%</td>
</tr>
<tr>
<td>NASA</td>
<td>$8.926</td>
<td>$0.726</td>
<td>8.13%</td>
</tr>
<tr>
<td>NSF</td>
<td>$7.17</td>
<td>$0.586</td>
<td>8.17%</td>
</tr>
<tr>
<td>Department of Energy</td>
<td>$4.9</td>
<td>$0.4</td>
<td>8.16%</td>
</tr>
<tr>
<td>NOAA</td>
<td>$3.157</td>
<td>$0.257</td>
<td>8.14%</td>
</tr>
<tr>
<td>USGS</td>
<td>$1.088</td>
<td>$0.09</td>
<td>8.09%</td>
</tr>
<tr>
<td>FEMA</td>
<td>$0.946</td>
<td>$0.055</td>
<td>5.81%</td>
</tr>
<tr>
<td>EPA</td>
<td>$0.795</td>
<td>$0.065</td>
<td>8.18%</td>
</tr>
<tr>
<td>Coast Guard</td>
<td>$0.033</td>
<td>$0.002</td>
<td>6.06%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$148.834</strong></td>
<td><strong>$12.134</strong></td>
<td><strong>7.71%</strong></td>
</tr>
</tbody>
</table>

Table 1: Values from ScienceInsider. Raw Department of Defense numbers and numbers for Coast Guard and FEMA from the Office of Management and Budget report to Congress.

The future is all the more sobering when one realizes that the cuts to NIH represent just over 20 percent of the total cuts to science funding, although they will have a disproportionate impact on biomedical research, where the NIH contributes 28 percent of all funding. Department of Defense Research cuts alone are nearly three times the losses to NIH. The first instinct might be to dismiss losses there as irrelevant to biomedical research. However, that funding source is the life blood of many biomedical research projects. Just one group within the Department of De-
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Registration begins November 2012
might mean for Physician-Scientists: “Emergency Medicine and Emergency Care Research is one of the more popular potential career choices” among physician-scientist trainees, and “having a body of individuals… at the NIH that can state the value of Emergency Care Research can certainly provide an affirmation that Emergency Care Medicine or Research is a viable career choice. Current students… would therefore have greater options”

The OECR was created in answer to four reports released in 2010 that outlined the apparent barriers to research in emergency medicine: NIH and Research in the Emergency Setting: Progress, Promise, and Process; the Summary of NIH Medical-Surgical Emergency Research Roundtable (April 30 to May 1st, 2009); the NIH Roundtable on Opportunities to Advance Research on Neurologic and Psychiatric Emergencies; and the NIH Roundtable on Emergency Trauma Research. Many of the needs outlined in these reports can be answered readily by properly trained individuals from physician-scientist programs in particular. One of the important recommendations cited several times in the reports themselves called for training emergency care investigators using research training programs. One of the few extant training modalities capable of meeting these needs are, of course, the very physician-scientist programs many of us are already associated with.

Because of this, current physician-scientists and physician-scientist trainees who are interested in emergency medicine may be able to take advantage of the OECR. While the OECR itself is not a direct funding entity of the NIH, it still may prove to be very useful in regards to both training and funding for those considering this area of research. As the OECR is designed to serve as a mechanism for advancing both research and research training in emergency care, some of the goals OECR relevant to physician-scientists include “foster[ing] career development for trainees in emergency care research,” and “coordinat[ing] funding opportunities that involve multiple NIH institutes and centers.” To clarify this, Dr. Baren points out that “The OECR can provide a terrific forum for institutes and center directors to talk about joint funding of research projects. It is currently hard for trainees to find out where they may get funding from due to how Emergency Care Research spans multiple institutes. [The OECR] does not have a dedicated funding stream at this time… but it can serve as a bridging program between institutes for trainees.”

Another primary benefit of the OECR as put forward by Dr. Baren is that the OECR “is finally a place where people can have a dialogue about how people can approach a problem that goes beyond an organ system. Emergency Care Research deals with undifferentiated diseases. With cardiac arrest, you can’t easily separate the damage in the brain with the damage going on in the myocardium.” This has previously been a stumbling block, as a great deal of research in emergency care has been “Stymied, because people could not appreciate that there were multiple organ systems involved.” Dr. Baren has stated that one of the major goals of setting up this new office at the NIH was to increase the pipeline of physician-scientists that would go on to choose Emergency Care Research. The OECR may eventually provide more training programs, taking the focus off of emergency physicians and broadening the focus to any physician-scientist that is interested in acute and emergent disease processes.

Because the OECR was only announced at the end of July, there has not been much time to directly experience what the OECR will be able to offer us as physician-scientists. The coming months will hopefully demonstrate some of the benefits that a dedicated office can provide to emergency care research, and to physician-scientists interested in emergency medicine in particular.

Surgery (cont. from page 3)

help understand and evaluate the feasibility of a surgical subspecialty as a career path for physician-scientists who want to stay actively engaged in research. I will also highlight special considerations for minorities and female surgeon-scientists.

Having been interested in pursuing the MD-PhD since 7th grade, I have thought long and hard about how to plan my training and my future career. I had foreseen myself as a perfect fit for the 20-80 physician-scientist model, and a proponent of the “translational scientist” who “bridges the divide between science and medicine.” However, as an undergraduate, an MD-PhD applicant and even during most of the last two years of medical school, surgery had never crossed my mind. I idealized an image of serving as an attending in an internal medicine subspecialty with the occasional month or two weeks on service, and devoting the majority of my time and energy to basic science research. I even admit to seriously contemplating anesthesiology, but never surgery.

Yet after spending 6 months on the wards, first in medicine and then in surgery, I knew instinctively that surgery was the right choice for me. I have always loved to work with my hands, valued the ability to deliver definitive therapy, and deeply valued the absolute trust patients place in their surgeons. But even before my love affair with surgery really began, it dawned on me that a decision to pursue a surgical or procedurally intensive field warrants serious consideration as a woman and as a physician-scientist, not to mention as both. How feasible is it to navigate a career that combines basic research with an active surgical practice? And how much harder is it to do both with success?

To really assess these concerns, one needs to look long and hard at the training pathway required. For most surgeons, the training time required for specialties through a traditional general surgery residency border on the range of 7-10 years after accounting for 1-3 years of fellowship. Yet, most surgical trainees do not have adequate research time to keep up-to-date on research advances or technical laboratory skills. Indeed, how old will I be when I write my first R01?

To be continued…

PM&R (cont. from page 3)

them to a career in research but are considering PMR.

Given the opportunities for research in PMR, what might draw a student to the field? In some specialties, the connections are obvious. A student whose passion lies in the biogenesis of cancer might gravitate to oncology. For another trainee examining the pathogenesis of allergy and asthma, pulmonology might seem a perfect fit. Compared to these, PMR might seem harder to match an interest to for a future researcher, with its general focus on rehabilitation of conditions as varied as limb loss and traumatic brain injury.

However, PMR’s lack of specificity offers its own advantage, namely that it has opportunities for students with a wide variety of seemingly-unrelated interests. For the student of neuroscience, work taking place at the aforementioned Spaulding Rehabilitation Network demonstrates the possibilities of a career in PMR, with one researcher leading a multimillion-dollar NIH-funded project investigating the treatment of patients with disorders of consciousness. PRM also offers a unique opportunity for the student interested in robotics or engineering, with groups at the University of Texas and the Department of Veterans Affairs (VA) investigating the latest in robotic prostheses for amputees and patients with spinal cord injuries. The fields of computer science, neuroscience, and engineering combine in recent findings from a multidisciplinary and multi-institutional group working on a project called BrainGate. These researchers seek a functional interface between the brain and computerized electronics, whether powering a robotic prosthesis for a patient with spinal cord injury or navigating a web browser for someone without the use of their arms. These and many other current projects within PMR demonstrate the many possibilities of the field for interested trainees.

PMR, like any specialty, is not for every student. All trainees considering which field to pursue should take great care to choose a specialty that fits their interests and that will inspire them to give great care and do great research throughout their careers. Trainees must avoid outright dismissal of PMR and similar fields as unsuited to a physician scientist career. The traditional fields suit many trainees, but every field has something to offer interested students. Just as students are taught not to succumb to absolutes, such as antibiotic X always working against pathogen Y, they must not succumb to absolutes regarding the suitability of a particular field for a physician scientist. With careful consideration and hard work, PMR could provide a fulfilling clinical and scientific career.
Budget (cont. from page 4) fense, the Defense
Advanced Projects

Research Agency (DARPA), has supported numerous initiatives
ranging from $3.7 million for the McGowan Institute for Regenerative
Medicine at the University of Pittsburgh to a recent work
published in Science that describes electronics that harmlessly
degrade in water, a potentially revolutionary finding for im-
plantable medical devices. Loss of these other funds represents
another great blow to researchers and trainees.

Table 1: Proposed Budget Cuts by Program

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget (billions)</th>
</tr>
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<td>1999</td>
<td>25</td>
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<td>2000</td>
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<td>2011</td>
<td>28</td>
</tr>
<tr>
<td>2012</td>
<td>28</td>
</tr>
<tr>
<td>2013 (proposed)</td>
<td>35</td>
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</tbody>
</table>

However, suppose a solution is found to the immediate funding.
Just as Congress wrote sequestration into law, Congress can
cancel it, most likely in a punt of the ultimate resolution to the
next session of Congress. Such a solution may already be in
place by the time you read this. Where does that leave science?
Unfortunately, recent trends in NIH funding provide a sobering
picture. As Figure 1 demonstrates, NIH funding has stagnated
since 2002. At that same March subcommittee meeting, Dr.
Collins spoke of shuffling funds around rather than announcing
broad new initiatives. Proposals to place increased scrutiny on
those researchers receiving more than $1.5 million in NIH fund-
ing to provide a greater number of grants overall speaks to the
research climate in the US today. Adjusted for inflation, total
NIH funding is a fifth less than a decade ago. Success rates for
grant applicants fell from 31 percent in 2002 to an all-time low
of 18 percent in 2012. With the pending cuts, that rate threatens
to decline all the more. Established researchers may find pro-
jects unfunded, leaving them and their trainees without a future.
New graduates seeking to begin their scientific careers will find
their first grant application facing a journey through which few
will survive. Research is not easily idled until the economic
winds blow more favorably. A scientist who loses their grant or
who must wait years before getting a grant accepted may find
themselves not on hold but out of the field entirely. More sober-
ing is the realization that many of these years of no budget in-
creases occurred prior to the beginning of the great recession, a
time when concerns of deficits or budgets were little heeded in
Washington. Policy makers have evidently determined that sci-
ence funding is not a top priority.

Writing in the August 23, 2012 issue of the New England Jour-
nal of Medicine, Drs. Sun, Steinberg, and Jagis tackle this very
issue, contrasting the attitude of the United States with that of
several rising Asian nations. Where the US has left budgets
stagnant, many of these other nations have and continue to in-
crease them. With a GDP in 2011 of $15 trillion and total fiscal
year 2013 US research spending for the major funding agencies,
without sequestration, at $148 billion (Table 1), the US devotes
less than 1 percent of GDP to research funding. Compare this to
India, striving to spend a minimum of 2 percent of GDP on med-
ical research alone by 2010, or China, striving to spend 2.5 per-
cent of GDP on scientific research by 2020. While the amounts
they spend today may pale in comparison to just one of the
NIH’s several institutes, the increases year-over-year are impres-
sive: from 2009 to 2010, China, India, South Korea, and Singa-
pore increased research spending by 67, 15, 24, and 13 percent,
respectively. Economic realities may force these and other na-
tions to reduce their ambitions, but even the much smaller in-
crease of Taiwan, 3.8 percent, must have institute and agency
directors in the US green with envy. If the US is to maintain its
primacy in the research world, a concerted effort to increase
science funding is not just a good idea; it is a necessity. Should
spending remain flat, to say nothing of potential cuts, US re-
searchers face worsening of the present condition, where ever-
more scientists compete for ever-fewer funding opportunities,
discouraging young people from entering the field and forcing
many established researchers out entirely.

What can scientists, including trainees, do to change this future?
The answer lies in remembering who benefits most from re-
search dollars. Hitherto, the only stakeholders mentioned have
been scientists and the agencies that fund them. However, if
funding priorities are to change, the most important constituency
of all must be enlisted: the American people. From DARPA’s
role in the internet’s birth to every medical treatment made pos-
sible by NIH funding, the benefits of scientific research are clear
and widely accepted by the public, with multiple surveys
demonstrating strong support for science amongst the American
people. Strong public support for science allowed NASA’s
budget to soar during the space race and the NIH’s budget to
double in the years before 2003. Capturing existing support and
couraging non-scientists to voice their support for scientific
research to their congressmen and women is the most powerful
way to not only stop cuts but also to turn them into increases.
Without that support, individual scientists and scientific organi-
izations may declare the current state of affairs a tragedy until
they are blue in the face, receiving little for their efforts but
empty promises and a frozen budget.
Let your voice be heard today: Join an APSA Standing Committee!

APSA works hard to support physician-scientist trainees, but we cannot do it without your help. Apply for a Standing Committee position today!

APSA’s five Standing Committees keep APSA running and plan all APSA events and initiatives. Don’t let your voice go unheard; become part of one today!

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Scenes from the 8th APSA Annual Meeting, Chicago, IL (April 27-29, 2012)