Advice to Mid-Career Clinician-Investigators on Sustaining a Funded Research Career

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When the Research Committee met at the recent SGIM national meeting in Denver, we brainstormed about new projects for the coming year. A few of us shared our interest in revitalizing the “Funding Corner” section in Forum, and I volunteered to author the first column.

I had a conversation with Christina Wee, our Research Committee chair, and we compared strategies we’ve used to stay funded in our research careers, beyond our respective career development awards. I asked Christina the question, “What general advice on funding would you give to mid-career clinician-investigators?” Here are some of our ideas.

Have a long-term plan. Think two to three years ahead. Try to leverage what you are working on now to support future proposals. Christina suggested, “Do something you love because you may be working in that field for a long time.” At the same time, have the flexibility to switch if opportunities arise.

Apply to NIH institutes/foundations that are friendly to general internal medicine (GIM) research. Christina has obtained most of her funding from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) but believes, based on her trainees’ and colleagues’ experiences, that the National Institute on Aging (NIA) and the National Cancer Institute (NCI) are friendlier to the kinds of research GIM investigators conduct; I have had success at the Agency for Healthcare Research and Quality (AHRQ), National Heart Lung and Blood Institute (NHLBI), National Institute on Drug Abuse (NIDA), and the American Cancer Society (ACS).

Stretch the duration of grants for as long as you can. Make the grant go an extra year (using no-cost extensions when necessary), and don’t write an overly lean budget, especially given across-the-board funding cuts at the NIH.

Consider the multi-PI structure. This is an arrangement where two principal investigators have equal responsibility and accountability for leading and directing the project. I have partnered with colleagues who have complementary expertise to my own in projects funded by NHLBI and NIDA. I find that “two minds are better than one” and that I feel less “alone” in the struggle to stay funded. The downside is that the new investigator advantage does not apply in a multi-PI situation; once you become a multi-PI on an R01, you lose your new investigator status.

Consider applying for a K24 mentoring award, if you love to mentor. Christina currently holds a K24 from NIDDK.

Be persistent. Here’s an example: In the fall of 2010 I applied for an R21 to NCI to conduct a pilot randomized controlled trial of patient navigation to promote engagement in smoking cessation treatment among poor and minority smokers. The proposal received two good reviews and one bad one and was not scored. I then shrank the proposal down to a $25,000 one-year budget, and it was funded through an internal pilot grant mechanism supported by my institution’s Clinical and Translational Science Institute. I then used that pilot data to apply for an R01-equivalent grant from the ACS; after revising and resubmitting once, the proposal was rated “outstanding” but missed the pay line. Now I’m planning to re-submit it to ACS to be reconsidered (without revisions) and at the same time contemplating a new R01 submission to NIDA, using the multi-PI mechanism, to focus on smokers with addiction and mental illness. (In fact, I’m procrastinating working on that proposal by writing this article….)

Take on administrative roles with caution. Christina advises, “Know your value and what you are worth; you need to be compensated for the time it takes to do the job otherwise your research time might be subsidizing your administrative role.” Christina serves as the Beth Israel-Deaconess program director for the Harvard GIM Fellowship, as well as associate section chief for research in her division. I have recently taken on the role of director of quality for the section of GIM at Boston Medical Center. Given that my research focus is improving quality of care in primary care for underserved patient populations, serving as quality director in a safety-net hospital can inform my research, and vice-versa.

Have a backup plan. Luckily, we are all clinicians and can always see more patients in primary care if the grants don’t get funded. My other backup plan has been to work as a Suzuki cello teacher—I hear there is a shortage of them.