posal is inherently riskier than an R01, says Harry Tyrer, a University of Missouri computer scientist and chair of a special SBIR study section, because it's examining the commercial feasibility of an idea. "The whole point is to see whether the idea works or not," he says.

But Rich insists that the difference in scores reflects an imbalance in quality. "Reviewers know what a 150 [score] means, even if it is in a different context," he says. "I don't buy for a second that a 150 on an R01 means the same thing as a 250 does on an SBIR." And quality isn't the only issue. Rich and other FASEB officials also feel that NIH shouldn't be in the business of moving new discoveries from the bench to the drug counter or supply catalog. "If it's such a good idea, then the private sector will pick it up," he says.

However, that's not the way the world works, explains physicist Gerd Muehllehner. Muehllehner took a sabbatical from the University of Pennsylvania in 1988 to start UGM, a small Philadelphia company that makes million-dollar positron emission tomography scanners. But he says he would have headed back to academia if he had failed to obtain an SBIR award. "We tried to go the venture capital route, but they wanted to see a prototype. And big companies rely on small companies to do innovation," says Muehllehner, whose company now markets its products through General Electric.

Muehllehner admits that it took longer than he expected to get his company on its feet. But this month he's adding four scientists to his 11-person staff, and he no longer has second thoughts about his decision: "I spent 15 years of my life developing this idea, and now we're having an impact on the market. And we wouldn't exist without SBIR."

Success stories like Muehllehner's make a powerful political statement. Moreover, before Porter can limit SBIR's growth at NIH, he must get authority to modify the existing law. If he succeeds, the debate would then shift to the value of the program itself. Regardless of which side wins, one of the government's least known billion-dollar research programs is about to get some attention.

–Jeffrey Mervis

CLINICAL RESEARCH

UCSF, Stanford Hospitals to Merge

Like pressure that builds along a fault before a big quake, tension is rising at some of the nation's top medical research centers as their leaders plan for restructuring. Across the nation, teaching hospitals are preparing to streamline, downsize, and forge alliances with old competitors in order to cut costs. Some medical specialties and research projects may feel the impact, and already one national medical group is trying to anticipate the size of the jolt.

A preview of the kind of change that will affect these academic centers came last year in Boston, where the Harvard-affiliated Massachusetts General Hospital merged with Brigham and Women's Hospital (*Science*, 19 May 1995, p. 968). This spring, the action is heating up on the West Coast, where demands for efficiency are driving the teaching hospital of the University of California, San Francisco (UCSF), into the arms of Stanford University. The UC regents were planning to review a merger proposal this week, and Stanford's trustees are scheduled to consider it in early June. Other medical schools around the country are talking about consolidation, and the list of those reported to be in the market for mergers seems to grow every month (see table).

TEACHING HOSPITAL MERGERS
(Actual and Potential)

Boston	
Massachusetts General	Brigham and Women's (completed)
Beth Israel	Deaconess and Mt. Auburn hospitals
Boston City Hospital	Boston University Medical School
Tufts NE Medical Center	Caritas Christi hospitals
San Francisco	
UC San Francisco	Stanford (expected 1997)
New York	
Mt. Sinai	New York University (?)
Columbia University	St. Luke's Medical Center (?)
Indianapolis	
Indiana University	Methodist Hospital

Driving this reorganization of academic medicine is the demand by health care financing systems that academic health centers match the efficiency of nonresearch hospitals. Funds for research are likely to get caught in the squeeze, says Paul Griner, former director of Strong Memorial Hospital at the University of Rochester. The magnitude of the effect is hard to predict, he notes. But he estimates that as much as 20% of research funded at institutions belonging to the Association of American Medical Colleges (AAMC) has been paid for in the past by hospital charges and faculty fees for medical services—funds that will be tighter in the new world of cost-cutting megahospitals.

Officials at UCSF and Stanford began their talks last summer, and in November, they publicly acknowledged that the process was going forward. In recent weeks, they've begun briefing medical service employees and faculty members on how the union could affect individual departments. According to spokespersons for both universities, the Stanford-UCSF alliance could be finalized this year. Although the specifics are still under negotiation, the broad plan has been described by Peter Van Etten, president and CEO of Stanford Health Services, and by UCSF Medical Center chief William Kerr. The objective is to unite the medical services of the two institutions under an independent administration while keeping the teaching functions separate.

By reorganizing, the schools hope to put a lid on operating expenses, including salaries. Van Etten has said that the schools expect to gain additional savings through joint purchasing deals, combined administration, joint capital investment, and elimination of overlapping clinical specialties. UCSF medical school Dean Haile Debas conceded recently that the new structure would mean some loss of control for medical school officials, but said that "we emphatically believe that a combined organization would be in a stronger position to continue, over the long term, to provide competitive salaries, benefits, and jobs than either UCSF or Stanford would be by attempting to survive on its own in the new managed-care environment."

Independent auditors are now combing the books of both schools, searching for functions that need to be stitched together or cut out. One of the big issues that remains obscure is how much money the cost cutters will allow for research. But Stanford medical school Dean Eugene Bauer stressed the positive, saying he hopes that the merger will make it easier to collaborate on research projects.

Similar questions are likely to come up elsewhere, says Griner: The merger of UCSF and Stanford, "is a good example of the things that have occurred elsewhere and are likely to occur in large-volume markets" around the nation. The AAMC has set up a special unit to keep an eye on these changes and collect data as mergers get under way. The project began to take shape about 6 months ago at AAMC headquarters in Washington, D.C., under Griner's direction. Griner has now finished hiring members of a team that will monitor a "sentinel network of 15 to 18 diverse and representative" medical schools.

The next regions likely to be swept by mergers, predicts Griner, are New York, where several academic health centers are already in pursuit of business partners, and Chicago, where at least six major teaching hospitals compete for patients. The full impact of the quake hasn't hit the clinical research labs as yet, Griner says, but "we are all predicting that it will be significant."

–Eliot Marshall