

**STATEMENT OF  
Dr. Elizabeth Ginexi, Ph.D.  
Research Scientist  
Former Senior Program Director, National Institutes of Health  
before the  
House Committee on Oversight and Government Reform  
Task Force on the Declassification of Federal Secrets  
U.S. House of Representatives  
June 30, 2026**

Chairman Luna, Ranking Member Crockett, and distinguished Members of the Committee:

Thank you for the opportunity to testify today.

I am a health research scientist. I earned master's and doctoral degrees in psychology from The George Washington University, and completed postdoctoral training at Children's National Hospital and at Vanderbilt University.

I spent 22 years from 2003-2025 as a Scientific Program Official at the National Institutes of Health (NIH), managing a portfolio of more than \$132 million in health research grants, co-authoring 18 federal funding programs that generated \$778 million across more than 1,000 awards, and working alongside the scientific community that makes this country's biomedical enterprise function. I left NIH in April 2025. Since then, I have been documenting what is happening to the institution I helped build.

I am here to testify that the changes underway at NIH are not reforms. They are a transfer of authority from scientists to political appointees, and the consequences for American health and economic competitiveness are not theoretical.

**What federal investment in biomedical research has produced**

For 80 years, the United States government built the most productive publicly funded biomedical research enterprise in human history. The returns are documented, specific, and large.<sup>1</sup>

Heart disease is the leading cause of death in the United States. NIH-funded research on blood pressure, cholesterol, and smoking drove a 56 percent decline in heart disease deaths between 1950 and 1996.<sup>1</sup>

Cancer has been transformed. Treatments for breast, lung, prostate, and childhood cancers, along with immunotherapies that have converted previously fatal diagnoses into manageable conditions, trace directly to NIH-funded investigations into tumor biology, immune function, and genetic mechanisms.<sup>1</sup>

HIV and AIDS were a death sentence in 1981. Pharmaceutical companies saw no profitable market for treatment. NIH-funded researchers developed AZT and ran the clinical trials no private company would touch. What followed was antiretroviral therapy and pre-exposure prophylaxis. Global AIDS deaths, which peaked near 2 million annually around 2004-2005, have fallen 54 percent since 2010. More than a million people are alive today because of NIH research.<sup>1</sup>

Polio paralyzed tens of thousands of American children annually in the early 1950s. NIH-supported research produced the vaccines that ended that threat in this country. The same is true for hepatitis B, HPV, and COVID-19. The mRNA platform that produced COVID vaccines in record time was built on decades of NIH-funded basic research during periods when clinical application was far from guaranteed.<sup>1</sup>

Rare diseases, which affect 25 to 30 million Americans in aggregate, receive research attention from the NIH precisely because no market exists to study them.<sup>1</sup>

Neurological research with no obvious commercial target produced the understanding of brain chemistry that gave us modern pharmacological treatments for depression.<sup>1</sup>

NIH-funded research on infant sleep position reduced sudden infant death syndrome deaths by more than 50 percent.<sup>1</sup>

These outcomes share a pattern: basic research, funded by the public, whose value became visible only years or decades later. Not one of them would have been produced on a market timeline. Every dollar appropriated to NIH generates \$2.46 in economic output.<sup>1</sup> NIH-supported work contributed to 354 of 356 new drugs the FDA approved between 2010 and 2019.<sup>2</sup> The pipeline that produces those approvals begins with basic research that has no immediate commercial application. Cutting the source of funding does not slow the pipeline. It ends it.

### **What is now at risk**

The NIH grants system was designed by the Public Health Service Act of 1944 (42 U.S.C. § 201 et seq.)<sup>3</sup> based on a clear principle: scientific judgments should be made by scientists, through accountable deliberative processes, insulated from political direction. That design choice is what produced the outcomes I just described.

The actions of the current administration, and particularly OMB, directly threaten that design. With this rule, they are trying to dismantle the NIH.

The proposed OMB "Regulation for Federal Financial Assistance" (2 CFR Part 200)<sup>4</sup> rule would give political appointees the authority to terminate funded NIH grants at any time, without cause. This means an ongoing clinical trial, one that has already enrolled patients, could be canceled mid-study based on political preference rather than scientific or ethical review.

That is not a hypothetical risk. NIH has already terminated or frozen thousands of research grants since January 2025.<sup>5</sup> The cancellations have been disproportionately concentrated in infectious disease research, vaccine research, and health disparities work.<sup>5</sup> As of April 2026, at least 5,468 NIH grants were terminated or suspended with over \$450 million in funds still lost, even as grants were ordered restored by the courts.<sup>5</sup> As of late 2025, 383 clinical trials testing treatments for conditions such as cancer, HIV/AIDS, mental or behavioral health conditions, substance abuse, and chronic diseases had lost grant funding with more than 74,000 patients directly impacted.<sup>6</sup> The proposed rule would make that authority permanent.

Inside NIH, the Director, Jay Bhattacharya, has overseen the elimination the merit score thresholds that once gave peer review its structural integrity.<sup>7,8</sup> Previously, applications scoring above an objective score had a strong likelihood of funding based on scientific merit. That threshold has been removed, with final funding decisions transferred to political appointees who are, right now, overriding peer review outcomes based on whether research aligns with administration priorities in accordance with OMB directives.<sup>9</sup> Hundreds of grant applications are being held up at any given time by unprecedented scrutiny after peer review.

The proposed OMB rule would also impose severe restrictions on international research collaboration, severing the partnerships essential to pandemic preparedness and global disease surveillance. The United States is currently managing an H5N1 bird flu outbreak with more than 70 documented human cases.<sup>10</sup> A hantavirus outbreak linked to a rare strain from South America required CDC scientists to work alongside Argentine public health officials to trace its origins.<sup>11</sup> An Ebola outbreak in the Democratic Republic of Congo, now the third-largest on record, is outpacing containment efforts as of this week.<sup>12</sup> Each of these required or requires exactly the kind of international scientific cooperation the proposed OMB rule would make structurally harder to maintain. This is the moment the administration has chosen to restrict essential cooperation and funding.

### **What cannot be rebuilt**

Between 2025 and January 2026, federal research agencies lost STEM PhD scientists over new hires at a ratio of 11 to 1, a net loss of more than 4,000 researchers according to a *Science* analysis of federal workforce data.<sup>13</sup> NIH experienced the highest number of PhD losses among all federal agencies, with 1,112 PhD-trained workers leaving their roles. At NIH, 13 of the 27 institutes and centers are operating without permanent scientific leadership.<sup>14</sup> The majority of NIH's 25 Advisory Councils, required by statute to provide independent scientific accountability, are operating with less than half their full membership.<sup>15</sup>

The expertise lost when researchers leave does not return when a budget line is restored. The knowledge infrastructure, once dismantled, does not snap back into place.

## What this Committee can do

The fundamental choice before this Congress is between a system where scientists make scientific judgments through accountable deliberative processes or one where political appointees make those calls instead. That choice will determine whether the next generation of breakthroughs in cancer, Alzheimer's, antibiotic resistance, and pandemic defense happens here, or somewhere else, or perhaps not at all.

### **I urge Congress to pass a joint resolution of disapproval to block the proposed OMB Federal Financial Assistance rule in its entirety.**

The proposed rule would replace the peer-review system of federal investment in science with a political approval process. This new political litmus test would extend to all grants issued by any federal agency, including funding for science, public services, infrastructure, and education. Using OMB's grants management authority as a vehicle for political control over federally funded grants has not been authorized by Congress or the Constitution.<sup>16</sup>

The United States built the world's preeminent biomedical research enterprise over 80 years. The speed of the current dismantling of the NIH is breathtaking. Rebuilding what has been lost, if it can be rebuilt at all, will take decades.

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## EDITORIAL



## The OMB and the Politicization of Science

The Editors

One of the great joys of working at a journal like ours is seeing the dramatic progress in patient outcomes that research can achieve over time. In the past few years, we've seen breakthroughs in cancer therapy, cures for genetic diseases, and new vaccines that prevent deadly diseases. These advances have been facilitated by the leadership, encouragement, and financial support of governments acting with the help of scientific advice. But such arrangements can go badly wrong. For decades, the Soviet Union promoted the unorthodox views of Trofim Lysenko, an agronomist who used his close ties to the political leadership to spread misinformation denying Mendelian genetics. What followed was a disaster: many years of poor harvests based on unsupported science and suppression of the teaching and practice of modern genetics throughout the Soviet bloc. A similar threat now hangs over U.S. science.

First, a review of where we are now. Proposals for scientific research are submitted to various federal agencies (we will use the National Institutes of Health [NIH] as an example), where they undergo an initial administrative review (to ensure adherence to all the rules) followed by peer review by a panel of experts in the field. These experts assess the proposal and assign it a priority score. Priority scores are based on the value of the science and are determined by peer reviewers who are shielded from politics. The appropriate NIH institute determines how many grants can be funded, depending on its budget, and then — with rare exceptions — funds strictly by priority score. The NIH leadership and Congress can influence funding by, for example, changing broad budgets or issuing “requests for

applications.” However, the decisions are almost entirely driven by science. Once funded, the proposed work proceeds, unless the grantee fails to perform it, for the period designated at the time of the funding decision.

The rule changes that the White House Office of Management and Budget (OMB) recently proposed to the Health and Human Services (HHS) grant process would drastically change this process. There are too many objectionable aspects of these proposals to discuss here. But three are particularly striking. Political appointees would be able to make funding decisions and could ignore the advice of independent scientists. They could also stop funding midway through the promised grant period. And they would institute new rules, including rules severely limiting foreign interactions. These changes raise fundamental concerns about the research endeavor, about ethical obligations to participants in clinical studies, about the ability to train the next generation of leaders in biomedical innovation, and about society's ability to address disease threats early, before broader consequences occur.

Giving political appointees ultimate authority to determine federal grant funding, as proposed by the OMB, would politicize and weaken biomedical research. Expert, independent peer review of grant applications is essential for directing NIH dollars to research that has the greatest potential for advancing science and improving health. Selecting the most promising research is an enormously complex and challenging undertaking, but over the past 70 years, scientific advances achieved with rigorous methods in clinical trials have improved quality of life, transformed human health, and extended life expect-

tancies. Substantial investment by the U.S. government built on the foundation of a merit-based review and award process has been central to these advances. A political process for awarding grants, by contrast, will end up harming patients and wasting resources. The OMB proposal indicates that grantees should conduct “Gold Standard Science,” a term that has been only vaguely described by the current administration (but, in a seeming contradiction to the OMB proposal, includes peer review). At the *Journal*, we know that what counts as gold-standard science can be determined only by peer review conducted by experts in the field — the current system.

The OMB proposal to permit political appointees to discontinue funding of ongoing grants at any time, without cause, would have serious adverse consequences for the research enterprise and for patients. In biomedical research, the gold standard of evidence is the randomized, controlled trial (RCT). The RCT’s methods minimize the influence of bias and preconceived notions. However, this type of trial often takes years to conduct and may take even longer for less common diseases. Once RCTs are initiated, alterations in their conduct, other than those made to incorporate new scientific evidence, undermine study integrity, participant safety, and trust in the outcome. For example, a trial to study a new agent to treat cancer may take a year or two to get funded, 3 to 4 years to conduct, and several more years of longer-term follow-up. If a decision to stop funding the trial occurred at year 4 for political rather than scientific reasons, what would happen to patients who were enrolled in the study at that time? How would longer-term safety and efficacy observations be made? This type of arbitrary midcycle termination of a clinical trial could place participating patients at significant risk of harm. Can physician–investigators ethically enroll a patient in a trial if ongoing funding for the trial is uncertain?

There would be substantial adverse effects on researchers as well as patients. Why would a basic science investigator start a line of investigation that might take years to complete if the funding for it could be cut at any moment, without cause? How could educators train the next generation of clinical investigators if their ability to complete their research were subject to the

whims of political appointees? A corrosive consequence of such an arbitrary funding process would be the diminishment of the U.S. workforce of clinical and basic science investigators — and it would ultimately harm biomedical innovation and cutting-edge patient care.

The proposed rules would also severely limit foreign research partnerships, requiring political approval of international collaborations. For the biomedical enterprise to understand the biology of important diseases, conduct studies of possible treatments for them, and potentially contain them, researchers need to study those diseases where they occur. Broad global collaboration has led to deeper understanding of genetic, environmental, and social factors contributing to disease manifestations and responses to therapy. For example, gastric cancer occurs at much higher rates in southeast Asia than in the United States. With the collaboration of clinical partners in regions with the highest burden of disease, studies can be completed years earlier than they would be otherwise, at a fraction of the cost, bringing earlier and greater benefits to all affected people, including people in the United States. Aren’t we better off addressing Ebola, tuberculosis, or screwworm before they spread to additional communities? Disease spread is typically easier to control when cases are fewer in number and contained in a limited geographic area.

A nonscientific, political process for determining what is scientifically sound has not worked in the past and will not work now. Lysenkoism demonstrated that allowing politics to control the scientific process can halt or even reverse a nation’s progress. Erratic funding would fundamentally undermine innovation and dramatically impair America’s ability to address today’s health challenges. The OMB proposal is currently open for public comment, and we urge our readers to express their concerns. When science becomes politicized, everyone loses.

*Editor’s note:* The OMB proposal is available for public comment at <https://www.regulations.gov/document/OMB-2026-0034-0001/comment>.

Disclosure forms provided by the authors are available with the full text of this editorial at [NEJM.org](http://NEJM.org).

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June 12, 2026

*Filed electronically via Regulations.gov*

Honorable Russell Vought  
Director, US Office of Management and Budget  
The White House

Re: OMB guidance governing federal grants and cooperative agreements  
*Regulation Codifying Policies on Federal Financial Assistance, Revisions to 2 CFR*  
91 Fed. Reg. 32198 (May 29, 2026)  
Extension of Comment Period to August 27 , 2026

Dear Director Vought:

The undersigned organizations across science, research, policy, and education come to you jointly to ask for a 45-day extension to the comment period for the proposed rule by the Office of Management and Budget to revise Title 2 of the Code of Federal Regulations, published on May 29, 2026. Presently, comments are due July 13, 2026 and we ask that on or before June 30, 2026 a Federal Register Notice is published extending the comment period to August 27, 2026.

The scope and impact of OMB's proposed rule is vast. The proposed rule amends 91 parts of Title 2 of the Code of Federal Regulations across 456 different sections of the regulations, adding 52 new subsections and fully restating 375 sections. The rule will impact the entirety of government grant-making across the United States. OMB itself says the revisions suggested would relate to over \$179 billion of funds to small entities. In addition to these entities, NSF reports that [\\$64 billion](#) was spent in FY2024 at universities on R&D, much of it through grants and cooperative agreements. NIH allocated approximately [\\$36.9 billion](#) in extramural funding that same fiscal year. These are just examples of the small but important components of the approximately [\\$1.2 trillion](#) that the federal government spends via grants and cooperative agreements.<sup>1</sup> A 45-day comment period is insufficient to allow completion of the multi-disciplinary analysis needed to provide useful feedback to OMB.

A 90-day period is warranted because this rule is complex and wide-ranging *and* never appeared on the Unified Agenda as a regulatory action being undertaken by OMB. The fact that no one in the regulated community was aware OMB was pursuing notice and comment rulemaking is evidenced in the fact that not one EO 12866 meeting was requested during the period this rule was under review at OMB's Office of Information and Regulatory Affairs.

Submission of substantive comments is fundamental to the rulemaking process under the Administrative Procedure Act, which at its core is about enhancing public engagement in rulemaking for the purpose of ensuring agencies receive the most comprehensive information possible to solve problems for the American people.<sup>2</sup> A fulsome and rational consideration of

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<sup>1</sup> Parts of the proposed rule do not apply to the full \$1.2 trillion in federal grant spending because there are exceptions for awards such as block grants, awards based on a statutory formula, and disaster-recovery grants, among other types of assistance.

<sup>2</sup> 84 Fed. Reg. 2139 at 2146-2148 (February 6, 2019).

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and response to data and evidence presented in public comments enables agencies to benefit when “situated knowledge” is shared as part of rulemaking efforts; in other words, public officials benefit from having access to knowledge that is widely dispersed among stakeholders.<sup>3</sup> “In particular, agencies need information from the industries they regulate, other experts, and citizens with situated knowledge of the field in order to understand the problems they seek to address, the potential regulatory solutions, their attendant costs, and the likelihood of achieving satisfactory compliance.”<sup>4</sup>

Many of us actively take steps as organizations or through our members to ensure the United States has the capacity to engage in ongoing and vital efforts to make progress in critical sectors as well as emerging fields. Many of us have worked with successive administrations and Congress on issues essential to the nation’s housing, energy, transportation, infrastructure, research and development, and healthcare systems, among others, that are regularly subject to federal grantmaking and cooperative agreements. Despite differences in approach, sector, and membership, each signatory has found it core to our mission to enhance the American innovation enterprise.

Executive Order 12866 states that agencies should “afford the public a meaningful opportunity to comment on any proposed regulation.” OMB envisions the proposed revisions of Title 2 of the Code of Federal Regulations will be a far-reaching reimagining of all forms of federal financial assistance. For a rule with these intended sweeping and comprehensive effects, a period of at least 90 days is needed in order for the comment period to be meaningful.

We value the opportunity to participate in the rulemaking and policy implementation process on the issues framed in the proposed rule, about which we care deeply, and appreciate your consideration of our request.

Respectfully,

ACA: The Structural Science Society  
Academic Pediatric Association  
Academy for Radiology & Biomedical Imaging Research  
Academy of Managed Care Pharmacy  
Academy of Physicians in Clinical Research  
AcademyHealth  
Acoustical Society of America  
ACRE  
Acterra: Action for a Healthy Planet  
ADAP Advocacy Association  
Afterschool Alliance  
Alliance for Academic Internal Medicine (AAIM)  
Alliance for Aging Research

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<sup>3</sup> M. Sant’Ambrogio and G. Staszewski, Michigan State University, [Public Engagement with Agency Rulemaking](#) (Administrative Conference of the United States, November 19, 2018) at p. 3.

<sup>4</sup> *Id.* at p. 10.

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Alliance for Data Science and AI  
Alliance for Learning Innovation (ALI)  
Alliance of Nurses for Healthy Environments  
Alliance to Cure Cavernous Malformation  
ALS Association  
American Academy of Allergy, Asthma & Immunology  
American Academy of Emergency Medicine  
American Academy of Hospice and Palliative Medicine  
American Academy of Neurology  
American Academy of Nursing  
American Academy of Pediatrics  
American Alliance of Museums  
American Anthropological Association  
American Association for Anatomy  
American Association for Cancer Research  
American Association for Dental, Oral, and Craniofacial Research  
American Association for Public Opinion Research  
American Association for State and Local History  
American Association for the Advancement of Science  
American Association of Colleges of Nursing  
American Association of Colleges of Pharmacy (AAPC)  
American Association of Geographers  
American Association of Immunologists  
American Association of Nurse Practitioners  
American Association of Physicists in Medicine  
American Association of Physics Teachers  
American Astronomical Society  
American Brain Coalition  
American Chemical Society  
American College of Obstetricians & Gynecologists  
American College of Physicians  
American College of Radiology  
American Educational Research Association  
American Federation for Aging Research  
American Gastroenterological Association  
American Geophysical Union (AGU)  
American Geriatrics Society  
American Heart Association  
American Industrial Hygiene Association  
American Institute for Medical and Biological Engineering (AIMBE)  
American Institute of Biological Sciences  
American Institute of Ultrasound in Medicine (AIUM)  
American Mathematical Society

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American Meteorological Society  
American Musicological Society  
American Nurses Association  
American Occupational Therapy Association  
American Oil Chemists' Society (AOCS)  
American Ornithological Society  
American Pediatric Society (APS)  
American Pharmacists Association  
American Physical Society  
American Physiological Society  
American Phytopathological Society  
American Political Science Association  
American Psychological Association  
American Public Gardens Association  
American Society for Biochemistry and Molecular Biology  
American Society for Bone and Mineral Research  
American Society for Cell Biology  
American Society for Clinical Investigation  
American Society for Clinical Pharmacology & Therapeutics  
American Society for Gravitational and Space Research  
American Society for Nutrition  
American Society for Pathobiology  
American Society for Pharmacology and Experimental Therapeutics (ASPET)  
American Society of Agronomy  
American Society of Biomechanics  
American Society of Civil Engineers  
American Society of Health-System Pharmacists  
American Society of Hematology  
American Society of Nephrology  
American Society of Plant Biologists  
American Society of Tropical Medicine and Hygiene (ASTMH)  
American Speech-Language-Hearing Association (ASHA)  
American Statistical Association  
American Studies Association  
American Thoracic Society  
American Vacuum Society (AVS)  
Americans for Medical Progress  
Animal Behavior Society  
Arkansas Immunization Action Coalition (Immunize Arkansas)  
Arthritis Foundation  
ASCP - Age Friendly Pharmacists and Pharmacies  
Asian American Scholar Forum  
ASM

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ASM International  
Association for Academic Pathology (AAPath)  
Association for Psychological Science  
Association for Research in Vision and Ophthalmology (ARVO)  
Association for Slavic, East European, and Eurasian Studies  
Association for the Sciences of Limnology and Oceanography  
Association for Women in Science  
Association of American Cancer Institutes  
Association of Art Museum Directors  
Association of Biomolecular Resource Facilities (ABRF)  
Association of Children's Museums  
Association of Environmental Engineering and Science Professors  
Association of Family Medicine Residency Directors  
Association of Maternal & Child Health Programs  
Association of Medical School Pediatric Department Chairs  
Association of Population Centers  
Association of Public Health Nurses  
Association of Research Libraries  
Association of Science and Technology Centers  
Association of Science Museum Directors  
Association of University Presses  
Autoimmune Association  
Big Cities Health Coalition  
Biocom  
Biophysical Society  
Botanical Society of America  
California Botanical Society  
California Institute for Regenerative Medicine  
California River Watch.  
California State University  
Campaign for Tobacco-Free Kids  
Campus Research Computing Consortium  
Cancer Nation  
Caregiver Action Network  
Center for Open Science  
Center on Budget and Policy Priorities  
Cereals & Grains Association  
Children's Cancer Cause  
Children's Hospital Association  
Clean Energy Business Network  
Climate Psychiatry Alliance  
Coalition for Academic Scientific Computation  
Coastal and Estuarine Research Federation

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College for Creative Studies  
Computing Research Association  
Concord Consortium  
Conference of Boston Teaching Hospitals  
Council of Medical Specialty Societies  
Crohn's & Colitis Foundation  
Crop Science Society of America  
CSM Advising LLC  
CT Public Health Association  
Cure Alzheimer's Fund  
Cure HHT  
Cushman Foundation for Foraminiferal Research, Inc.  
Dana-Farber Cancer Institute  
debra of America  
Defend Public Health  
DefendResearch  
Digital Promise Global  
Ecological Society of America  
EdTrust  
Education Reform Now  
Emory University  
Endocrine Society  
Entomological Society of America  
EveryLife Foundation for Rare Diseases  
Evidence Advocacy Center  
Federation of American Scientists  
Federation of American Societies for Experimental Biology (FASEB)  
Federation of Associations in Behavioral and Brain Sciences (FABBS)  
Fight Colorectal Cancer  
Fox Chase Cancer Center -- Temple Health  
Friedreich's Ataxia Research Alliance (FARA)  
Genetics Society of America  
Geological Society of America  
George Washington University Cancer Center  
German Studies Association  
Gerontological Society of America  
Global Health Technologies Coalition (GHTC)  
GreenLatinos  
HealthHIV  
Heart Failure Society of America  
Helminthological Society of Washington  
HIV Medicine Association  
Huntsman Cancer Institute

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IEEE-USA  
Illinois Public Health Association  
Immune Deficiency Foundation  
Infectious Diseases Society of America  
INFORMS  
Institute for Progress  
International Society for Stem Cell Research  
International Zebrafish Society (IZFS)  
Internet2  
Iowa Public Health Association  
Lasker Foundation  
Latino Caucus for Public Health (APHA)  
Lewy Body Dementia Association  
Lupus and Allied Diseases Association, Inc.  
Massachusetts Public Health Alliance  
Materials Research Society  
Mathematical Association of America  
MaxRevenue  
ME/CFS San Diego  
MEAction Maryland  
MEAction North Carolina  
MEAction, California  
Minerals, Metals & Materials Society  
Minnesota Public Health Association  
Montana Climate and Health  
NAPCRG  
National Alliance for Caregiving  
National Association for Biomedical Research (NABR)  
National Association of City Transportation Officials  
National Association of School Nurses  
National Ataxia Foundation  
National Consumers League  
National Council of Teachers of Mathematics (NCTM)  
National Council on Public History  
National Education Association  
National Foundation for Infectious Diseases  
National Health Council  
National Hispanic Health Foundation  
National Humanities Alliance  
National Low Income Housing Coalition  
National Medical Association  
National Organization for Dental Immunizers  
National Postdoctoral Association

Joint letter from 323 multi-sector organizations  
Request for 90-day comment period (45-day extension)  
June 12, 2026

National School Boards Association  
National Women's Law Center  
National Women's Studies Association  
Natural Resources Defense Council  
Natural Science Collections Alliance  
NDRI  
Nebraska Cures  
New America's Future of Work & Innovation Economy Program  
NJME/CFS Association  
North American Vascular Biology Organization  
Oceanography Society  
Optica, Advancing Optics and Photonics Worldwide  
Organization of Biological Field Stations  
Partnership for Public Service  
Pediatric Nurse Practitioner House Calls  
Pediatric Policy Council  
Physicians for Social Responsibility  
Planetary Society  
Plug In America  
Population Association of America  
Post-Acute and Long-Term Care Medical Association  
Prevent Blindness  
Psychonomic Society  
Pulmonary Fibrosis Foundation  
reDesignED  
Research!America  
RetireSafe  
Salem Oaks Consulting  
San Diego Natural History Museum  
San José State University  
Sanford Burnham Prebys Medical Discovery Institute  
Seismological Society of America  
SERP Institute  
Shock Society  
Sigma Xi, The Scientific Research Honor Society  
Social Science Research Council  
Society for Advancement of Chicanos/Hispanics and Native American in Science  
Society for Applied Anthropology  
Society For Biomaterials  
Society for Birth Defects Research and Prevention  
Society for Developmental Biology  
Society for Experimental Biology and Medicine  
Society for Glycobiology

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Society for Healthcare Epidemiology of America  
Society for Industrial and Applied Mathematics  
Society for Industrial Microbiology and Biotechnology  
Society for Laboratory Automation and Screening  
Society for Leukocyte Biology  
Society for Maternal-Fetal Medicine  
Society for Neuroscience  
Society for Pediatric Radiology  
Society for Pediatric Research (SPR)  
Society for Personality and Social Psychology  
Society for Range Management  
Society for Research in Child Development (SRCD)  
Society for the Psychological Study of Social Issues  
Society for the Study of Amphibians and Reptiles  
Society for the Study of Evolution  
Society for Women's Health Research  
Society of Behavioral Medicine  
Society of Environmental Toxicology and Chemistry of North America (SETAC North America)  
Society of Herbarium Curators  
Society of Nuclear Medicine and Molecular Imaging  
Society of Systematic Biologists  
Society of Teachers of Family Medicine  
Software & Information Industry Association  
Soil Science Society of America  
Solve M.E.  
SPARC  
Speculative Technologies  
Spina Bifida Association  
St. Jude Children's Research Hospital  
Stand Up for Science  
STEM Education Coalition  
Study Group  
T2M Advisors  
TERC, Inc.  
Texas Behavioral Science and Policy Institute  
Third Way  
TSC Alliance  
UCLA  
Union of Concerned Scientists  
University of Colorado  
University of Colorado Boulder  
University of Colorado Anschutz  
University of Kentucky Markey Cancer Center

Joint letter from 323 multi-sector organizations  
Request for 90-day comment period (45-day extension)  
June 12, 2026

University of Oregon  
University of Rochester  
Up for Growth Action  
Vision Zero Network  
West Sonoma County Alliance  
Wildlife Society  
Wistar Institute  
Women's Health Institute  
Woodley Park Institute

# The Bethesda Declaration One Year Later

## *Continuing Harms to the NIH Mission*

Developed by 74 concerned current and former NIH staff in their personal capacities, including anonymous contributors and:

1. Kathryn Adams;
2. Cara Anjos Breeden, MLS;
3. Wen-Ying Sylvia Chou, PhD, MPH;
4. Anna Culbertson BS, BA;
5. Susan M. Czajkowski, PhD;
6. Lee E. Eiden, PhD;
7. Marc S. Ernstoff, MD;
8. Hannah Evans, MS;
9. Benjamin Feldman, PhD;
10. Lori Frank, PhD;
11. Nina G. Friedman, BA;
12. Elizabeth Ginexi, MA, PhD;
13. Dave Gutekunst, PhD;
14. Kaitlyn Hajdarovic, PhD;
15. Andrea Horvath Marques, MD, MPH, PhD;
16. Sammy Katta, PhD;
17. Theresa Kim, PhD, MS;
18. Sarah C. Kobrin, PhD, MPH;
19. Rosa Lafer-Sousa, PhD;
20. Amber Lockridge, PhD;
21. Saul Malozowski, MD, PhD, MBA;
22. Mollie Manier, PhD;
23. Matthew Manion, PhD;
24. Vanessa C. McMains, PhD;
25. Ian Morgan, PhD;
26. Jenna M Norton, PhD, MPH;
27. Amy C. Palin, PhD;
28. Vani Pariyadath, PhD;
29. Rui C Pereira de Sá, PhD;
30. Shiv Prasad, PhD;
31. Christa Reynolds, MA;
32. Gina Roussos, PhD;

33. Katrina J. Serrano, PhD;
34. Siddharth Shenoy, PhD
35. Nina Silverberg, PhD;
36. Janine M. Simmons, MD, PhD;
37. Asha Storm, PhD;
38. Joanna Szczepanik, PhD;
39. Jennifer L. Troyer, PhD

## **Introduction**

Founded in 1887, the National Institutes of Health (NIH) is still the world's largest funder of biomedical research after more than a century. Currently, NIH has been at the forefront of scientific and technological advances that meaningfully improve the health of Americans and people across the globe: novel medications that prevent transmission of HIV; innovative technologies like CRISPR gene editing, AI-driven drug design, digital health technologies, and tissues on a chip; life-saving therapeutics for cystic fibrosis; a vaccine to prevent cancer; and cutting-edge treatments for diabetes, depression, Alzheimer's disease and obesity, among many others.

For over half a century, these NIH-led scientific advances have been fueled by consistent public funding from Congress, expert input from scientists, and global recruitment of top talent. Economists estimate that every dollar invested in NIH returns [\\$2.57](#) in economic activity per year and more than [\\$8.38](#) in private sector research and development over 8 years.

Last year, NIH Director Dr. Jayanta Bhattacharya released [scientific priorities](#) that claim to build on this success. Yet, Director Bhattacharya has repeatedly implemented policies and practices that not only undercut these stated priorities, but endanger the standing of the United States as a global leader in biomedical research.

One year ago, on June 9, 2025, we released the [Bethesda Declaration](#), an open letter of concern to Director Bhattacharya, Department of Health and Human Services (HHS) Secretary Robert F. Kennedy, Jr., and Congress. Signed by more than 600 NIH staff and 32,000 external scientists, patients, and members of the general public, the Declaration raised concerns about harmful policies that undermine the NIH mission, waste public resources, compromise the ethical imperatives of our profession, and threaten the health of Americans and people across the globe. These concerns include i) the politicization of NIH-funded science; ii) the interruption of global collaboration; iii) the undermining of peer review; iv) capping infrastructure support that is critical to science; and v) cuts in mission-critical personnel.

We hoped our Declaration might engender policy changes to prevent harm, improve public health, and ensure appropriate stewardship of public funds. When Director Bhattacharya held a roundtable with Bethesda Declaration signers on July 21, 2025, we had some optimism that we might together correct some of the most egregious threats to NIH. Ultimately, however, Director Bhattacharya largely ignored the concerns raised in our declaration and discussed during the roundtable.

Today, on June 9, 2026, we provide an update to members of Congress and the public on the current status of NIH, one year after the Bethesda Declaration. The chaos of 2025 has been replaced with coordinated, systematic, institutionalized destruction in 2026. NIH policy directed by HHS and the Office of Management and Budget (OMB) and implemented by Director Bhattacharya continues to flout ethical, statutory, and legal standards, including stipulations in the Public Health Service Act ([42 U.S. Code Chapter 6A](#)) for NIH to include diverse populations in research, address health disparities, conduct research related to the health of sexual and

gender minority populations, and enhance workforce diversity. Our initial concerns have only deepened as we've seen the consequences of this administration's policies: a [24% decrease](#) in new research funded by NIH in fiscal year (FY) 2025 compared to FY24; project terminations that have discarded investments in multi-year studies and [disproportionately](#) impacted early career investigators from minority racial, ethnic and gender groups; extreme [staff shortages](#); and dramatic [delays](#) in research awards. A May 29, 2026, proposed rule on the [Regulation for Federal Financial Assistance](#) from the OMB promises a return to the chaos of early 2025, codifying into regulation the policies and practices that enabled these harms. Despite the clearly documented negative consequences of such policies, Director Bhattacharya continues to [gaslight](#) the scientific community and members of Congress, insisting these challenges are just "political noise."

In this report, we expand on and provide further evidence that the five initial concerns outlined in the Bethesda Declaration remain critically urgent. The concerns include:

- Concern 1: An anti-science agenda is disrupting research for health advances and cures
- Concern 2: Discriminatory policies are worsening disparities
- Concern 3: Ignoring ethical standards has put research participants and the public at risk
- Concern 4: An unstable research environment is undermining scientific advances and public trust
- Concern 5: Lost critical expertise is hindering the NIH mission
- Concern 6: Changing of policies without staff input is creating foreseeable damage
- Concern 7: Cumbersome and shifting processes are wasting resources and harming health
- Concern 8: Disruption of global research is endangering people in the United States and around the world
- Concern 9: A culture of fear and low morale is eroding scientific integrity

We remain committed to the NIH mission, the United States Constitution, and the health and wellbeing of the American public. We sincerely hope that by continuing to shine a light on the harmful policies of current NIH leadership, we can advance meaningful reforms that will enable us to carry out the NIH mission: "to seek and apply fundamental knowledge to enhance health, lengthen life, and reduce illness and disability."

# **Concern 1: An anti-science agenda is disrupting research for health advances and cures**

## Why It Matters

Health advances require stable, long-term investment across multiple sectors and phases of the scientific process. Good stewardship of this investment demands constant monitoring and mid-course correction. Scientific expertise guides the weight given to innovative ideas – neither overvaluing original concepts in the face of robust evidence to the contrary, nor ignoring them simply because they are novel.

To find this balance, NIH has traditionally relied on two layers of peer review combined with programmatic guidance and oversight:

- **First level peer review: a merit-based review process involving external scientific experts.** NIH's peer review process occurs at multiple levels. In the first level, external scientists, who have a strong record of scientific accomplishment and are approved by NIH staff in the Center for Scientific Review (CSR), volunteer their time and expertise to judge the scientific merit of proposed research projects based on long-standing, regulatorily defined review criteria ([42 C.F.R. § 52h](#)).
- **Programmatic review by highly trained, nonpartisan civil servant scientists with expert knowledge in their fields.** These knowledgeable and experienced NIH scientific program staff are involved in the development of funding opportunities and funding recommendations. Specifically, program staff identify scientific gap areas where additional research is needed. They take input from external scientific advisory boards with relevant expertise (including patient advocates) as they develop funding opportunities to address identified research needs. They also make funding recommendations regarding applications in their area of expertise, informed substantially by the missions and strategic priorities of their NIH institute or center, scientific merit as judged independently by peer review, and scientific gaps and opportunities that guide NIH investment to improve public health. The funding recommendation process typically involves discussion among scientific program staff at the branch or division level, with Branch or Division Directors arbitrating the process and making final recommendations to the Institute or Center Director.
- **Second level peer review: Advisory Council Review by working scientists and patient advocates.** Each NIH institute works with a set of external scientific experts and individuals with lived experience, established through the Federal Advisory Committee Act ([5 U.S.C. § 1009](#)). Advisory Councils of scientific experts and community stakeholders guide programmatic decisions by NIH scientists, including development of funding opportunities and funding recommendations. The roles, requirements and functions of these advisory councils are defined in statute and regulation ([42 U.S.C. § 284a](#), [42 C.F.R. § 52a](#) and [42 C.F.R. § 52h](#)).

**Historically, the checks provided by this thorough and considered process have largely curbed the interference of politically appointed non-experts**, maintaining the stability and nonpartisan nature of scientific funding across changing political administrations. This stability is what has allowed scientists to do the long-term work required to develop treatments, optimize health, and save lives, positioning the United States as a world leader in biomedical research.

Currently, however, the system needs [reinforcement](#). NIH is implementing **policies that devalue scientific expertise in favor of politically motivated decision-making**. NIH is circumventing merit-based peer review, expanding the number and power of political personnel in positions of decision-making power at NIH, reducing the civil servant protections that enable a nonpartisan civil service to honestly share their scientific judgement, failing to ensure appropriate leadership across the NIH institutes and centers, with 14 of 27 directorships unfilled, and [neglecting](#) or [replacing](#) scientific advisory councils.

Devaluing scientific expertise not only breaks the long-established trust that researchers had in the federal science funding structure, but also erodes the American public's trust in science. Undermining peer review with a partisan, anti-science agenda wastes time and resources, shifts investments toward political allies rather than the most meritorious candidates, and damages the NIH's ability to support science that will improve the health of all Americans.

## Examples

**Grant terminations and political review undercut evaluations of scientific merit.** Every grant funded by the NIH undergoes multiple levels of extensive and rigorous peer review involving external and internal scientists. In recent decades, research applications are typically only funded when they score within the [top 20%](#), with few, unique exceptions. In early 2025, a small team of political appointees undermined this extensive, rigorous and transparent process by abruptly terminating ongoing science. Initially, these terminations were [carried out by](#) the Department of Government Efficiency (DOGE). But by April 2025, orders from Director Bhattacharya and Deputy Director Matthew J. Memoli compelled NIH civil servants to terminate existing grants. NIH [terminated 5,522 grants](#), even though they had been deemed meritorious by the rigorous and competitive review process. NIH terminated grants without regard to the content, quality, progress, or potential health impact of the science. Instead, terminations were based on [alleged discrimination](#) supposedly committed by the grantee institution or simply the [presence of words](#) or concepts that political leaders disliked. While terminations have become far less frequent, the threat of termination persists. All awards now must include a statement that the grant can be terminated based on misalignment with “agency priorities” that actually refer to terms deemed objectionable by the current administration. The context of how those terms are used does not matter. The existence of such terms in an application matters. Thus, grantees are compelled to comply with [censorship](#) from the Department of Health and Human Services and NIH, resulting in alteration of studies deemed important, rigorous, and feasible by peer review. Currently, practices controlled by the Office of Extramural Research (OER) within the NIH Office of the Director subject program staff and external investigators to a [discriminatory](#) and [cumbersome](#) screening and “renegotiation” process. NIH leadership has justified these acts by establishing the ill-defined concept of “Gold Standard Science” and then claiming that any

research project that doesn't align with the administration's political priorities does not meet the standard. The process is reminiscent of how the tobacco industry weaponized "[sound science](#)" to undermine research linking cigarettes to cancer.

**New policies undermine the first level of peer review.** Following an [Executive Order](#) from President Trump that suggested political appointees could override peer review, Director Bhattacharya issued his "[Unified Funding Strategy](#)," instructing NIH institutes to reduce the influence of peer review scores and expert feedback on funding decisions. The recent OMB [proposed rule](#) goes further, seeking to codify the minimization of peer review into regulations that carry the weight of law. NIH will soon seek public comment on a [proposal](#) to replace numerical peer review scores with a binning system that would cluster applications into three bins: "most competitive" (top 25%), "competitive" (26–50%), and "not discussed" (bottom 50% or unscored). The peer review score would be calculated, but *withheld* from program staff, Advisory Councils, institute and center leadership, and applicants, making a top-scoring first percentile grant indistinguishable from a grant at the 25th percentile. While [data](#) do suggest that scores within tight ranges may not reflect meaningful differences in science quality, binning scores across such broad ranges is not well supported by evidence and has not been piloted inside NIH. This system will remove valuable information from the peer review process, reduce transparency in funding decisions, and enable funneling of resources to NIH decision-makers' more favored pet projects, even if they are not deemed scientifically meritorious by peer review.

**Diminished roles of external scientific advisory boards reduce oversight.** To ensure NIH funding decisions are scientifically sound, [advisory committee](#) members must demonstrate integrity, be free from conflicts of interest, and have appropriate expertise. During the time-intensive process of appointing advisory committee members, NIH staff make every effort to ensure the committee not only has necessary scientific expertise but also is representative of the nation as a whole. Despite the critical importance of these committees, current NIH leadership has allowed the membership of many institute Advisory Boards or Councils to [dwindle](#). Because official concurrence from an Advisory Council legally requires a quorum, this poses a serious threat to the ability of NIH ICs to award grants at all. In addition, Director Bhattacharya completely [disbanded](#) the long-running Advisory Council to the Director. The NIH similarly dismissed all 28 members of the National Cancer Institute's [Board of Scientific Advisors](#), which for decades reviewed research and education projects. Other institutes [abruptly removed](#) individual members from Boards of Scientific Advisors, with dismissals primarily affecting non-U.S. citizens, women, people from racial and ethnic minority groups, and scientists focusing on topics disliked by the administration. Recent appointments to these Councils, such as [Kristine Blanche](#), wife of Acting Attorney General and former Trump lawyer Todd Blanche, raise concerns about partisan cronyism.

**Notices of funding opportunity (NOFOs) are delayed by political review.** Notices of funding opportunity are an essential tool for NIH to invite research applications addressing emerging or understudied research areas. Before publication, NOFOs undergo rigorous review by scientific program staff, institute and center leadership, and Advisory Councils. Prior to 2025, NIH typically released more than 700 NOFOs each year. As of March 25, halfway through fiscal year 2026, NIH [released just 17](#). This decrease is due to the insertion of new layers of [political review](#)

by NIH, HHS, and OMB, as well as OER directives limiting the number of NOFOs allowed. In some cases, notices drafted in January 2025 have yet to be released, because they are still awaiting political approval or political appointees have denied them. Having very few NOFOs delays opportunities to advance cutting-edge science and has forced NIH staff to choose between disrupting long-running programs that provide critical research services to the community or extending these programs without competition to ensure service delivery.

**A culture of fear silences scientific input from NIH staff.** NIH now suffers from a culture of fear and low morale as a result of threats to and retaliation against civil servant staff, as described in Concern 9. This has constrained the ability of NIH staff to deliver accurate and appropriate scientific feedback or highlight evidence to NIH leadership that conflicts with current Administration priorities. NIH staff fear will only escalate as NIH begins to [transition](#) career civil servant staff to [career/policy designations](#) that make their employment “at will,” as these changes enable politically motivated staff dismissals.

## Recommendations

- **Restore and bolster the outputs of first-level peer review at NIH** wherein expert panels impartially deliberate on the scientific merits of grant applications by 1) maintaining the availability of numeric scores, 2) ensuring that any binning systems provide sufficient levels of granularity and are piloted prior to broadscale implementation, and 3) ensuring funding decisions reflect input from peer review.
- **Safeguard the input of NIH scientific staff with expertise in relevant research areas on funding decisions**, ensuring that those who are charged with carrying out disbursement of public funds do so in a transparent, legal, and efficient manner. This will require an environment where staff can safely speak honestly. Sound funding decisions cannot realistically come from a few political appointees, even if they had relevant scientific expertise, as no individual alone can have the depth and breadth of expertise to cover all areas of health research within the NIH mission.
- **Support academic freedom at NIH for both intramural and extramural research staff.** Support the agency and authority of institute and center leadership and insulate these leaders from political winds. For individual intramural labs, support high-quality, curiosity-driven inquiries as reviewed by peer scientists. Deepening our understanding of biological processes through excellent fundamental research consistently leads to medical advances that arise from [unexpected areas of inquiry](#). For extramural staff, ensure staff feel safe sharing their honest scientific judgement and aren't penalized for raising scientific concerns.
- **Reconstitute and fully staff NIH Institutes' Scientific Advisory Councils and Boards.** Such boards should include scientists and patient advocates from relevant fields who have been well vetted for potential conflicts of interest, which include close connections with members of the administration or related financial stakes.
- **Restart and deepen collaboration with patients and other affected communities**, such as people living with or at risk for relevant health conditions and their caregivers, to ensure NIH research supports patient-centered outcomes. This should include continued

participation of relevant community members on advisory boards serving institute Advisory Councils, as well as community advisory boards to NIH-funded clinical studies.

- **Ensure future grant terminations only occur when justified** by scientific or ethical concerns, such as study futility, early determinations of efficacy, irreparably poor progress, unexpected participant harm, or investigator misconduct. Study terminations should ***not*** be allowed based on lack of alignment with politicized agency censoring set by any administration, as these will inevitably change every 4 to 8 years, creating whiplash in the scientific community and allowing completion of very few studies.

## **Concern 2: Discriminatory policies are worsening disparities**

### Why It Matters

As the nation's premier health research institution, the NIH must remain accessible to the best scientists of every demographic group and address the health of all people in our country. This approach is supported by both U.S. law and scientific evidence.

- **The law.** Discrimination based on race, color, religion, sex, national origin, or another protected characteristic (including gender identity) remains unlawful in the United States under the Civil Rights Act of 1964. The Public Health Service Act, the foundational statute for the NIH, requires the NIH director to: encourage grantees to “utilize diverse study populations,” develop a strategic plan that considers “biological, **social**, and other determinants of health that contribute to **health disparities**” and “encourage efforts to improve research related to the health of **sexual and gender minority populations**” ([42 U.S.C. § 6A](#)). The 21st Century Cures Act further mandates that the NIH Director shall “develop, modify, or prioritize policies, as needed, within the National Institutes of Health to promote opportunities for new researchers and earlier research independence, such as policies to increase opportunities for new researchers to receive funding, enhance training and mentorship programs for researchers, and **enhance workforce diversity**” (Pub. L. No. 114-255, 130 Stat. 1033, 2016).
- **The evidence.** Variation is central to health research, providing the necessary differences to create knowledge through comparison and ensure that research findings are generalizable. Excluding diversity along any axis (e.g., race, ethnicity, gender, ability, geography) removes the opportunity to learn from differences and makes findings less relevant and applicable in the real world. People from racial and ethnic minority groups, rural populations, LGBTQIA+ people, under-resourced communities, and people with disabilities often experience social and structural [barriers](#), such as transportation challenges, inflexible work hours, lack of childcare, and mistrust driven by historical and present-day traumas. These barriers contribute to [poor health outcomes](#) and [limit participation](#) in research to improve those outcomes. Including diverse populations in research requires intentional and focused recruitment, particularly of small populations, to study and overcome these barriers. Similarly, addressing health disparities requires research that both explicitly focuses on populations that experience worse health outcomes and considers the [contribution](#) of social and structural challenges. Finally, peer-reviewed research shows that diverse teams of people with different backgrounds outperform uniform [teams](#), as they are more likely to question assumptions, reveal blindspots, and generate innovation. This perhaps explains why diverse teams publish more frequently and receive more [citations](#). Prior to 2025, NIH policies supported broadening the NIH workforce by encouraging the mentorship, participation, and inclusion of people from diverse backgrounds, but never by determining funding based on any individual characteristic.

Despite the evidence in support of diverse study populations and researchers, under Director Bhattacharya, NIH has implemented policies that weaponize a poorly defined “DEI” (diversity, equity, and inclusion) label to eliminate a broad range of science-related efforts the administration finds convenient to target: inclusive study participation, minority health and health disparities research, and scientific workforce diversity.

## Examples

**A discriminatory screening tool is censoring NIH-funded research.** Despite his oft-repeated assertion that “there are no banned words,” NIH Director Jay Bhattacharya has mandated a [screening and “renegotiation”](#) process across NIH that is applied to every grant or application prior to receiving its first or subsequent installment of NIH funding. This screening process is being applied retroactively to grants that have already gone through a rigorous multi-level peer and programmatic review process in which they were evaluated as being innovative, scientifically meritorious, relevant to the health of the public, and worthy of funding. There are several hundreds of words being screened in this process. Funded projects affected by “renegotiation” have often been producing results for several years. The “renegotiation” [process](#) involves a “computational text analysis tool” that screens grants for “terms that may potentially be associated with misalignment with the agency’s priorities.” Any grants containing “misaligned” terms must undergo manual review by NIH program staff who must provide written justification for inclusion of the terms or engage in “renegotiation” with investigators and grantee institutions to remove the terms prior to initial or continued funding. On June 16, 2025, Reagan-appointed U.S. District Judge William G. Young issued a [ruling](#) on earlier, similar keyword-based screening processes at NIH, [calling](#) them an “effort to rubber stamp an ideological purge” and [declaring](#): “I am hesitant to draw this conclusion, but I have an unflinching obligation to draw it – that this represents racial discrimination. And discrimination against America’s LGBTQ community,” “I’ve sat on this bench now for 40 years. I’ve never seen government racial discrimination like this,” and “My [duty](#) is to call it out.”

Notably, the set of “misaligned” terms is not provided to the scientific community, nor is it provided to the majority of scientific program staff (including Program Officers and Grants Management Officials) within NIH. The set of terms has also evolved over time. NIH staff have compiled every “misaligned” term flagged by the tool between fall 2025 and early 2026 across four NIH institutes and provided the [list](#) to Congress. Terms the administration considered to “potentially be associated with misalignment with the agency’s priorities” during that period included “African American,” “Hispanic American,” and “Asian American.” (Notably, no grants were flagged for including “white American” or “European American.”) Grants are also flagged for terms such as “gender,” “health disparities,” “diverse,” “racial/ethnic minority,” and “Latinx.” These terms directly contradict the [framework](#) for federal public health programs and services set for NIH by Congress. In some cases, NIH scientific program officers are able to successfully justify these terms, but often their expert opinions are rejected. In addition, the heightened scrutiny introduces delays that disproportionately affect health disparities research and workforce diversity programs, each of which is [required](#) in NIH’s foundational statute. The screening process and threat of award termination or delay often pushes the scientific

community to self-censor their research for fear of being caught up in this discriminatory and cumbersome process. Concern about getting flagged in this screening process has caused some scientists to avoid health disparities research and programs designed to train the diverse workforce needed for excellent science and required by law.

**Civil rights law is weaponized against research on racial and ethnic minority populations.**

On February 10, 2025, a memo from then Acting Secretary of the Department of Health and Human Services Dorothy Fink stated: “The Department of Health and Human Services has an obligation to ensure that taxpayer dollars are used to advance the best interests of the government. This includes avoiding the expenditure of federal funds on programs, or with contractors or vendors, that promote or take part in diversity, equity, or inclusion (‘DEI’) initiatives or any other initiatives that discriminate on the basis of race, color, religion, sex, national origin, or another protected characteristic.” As a direct result of this memo, and in the absence of repeatedly requested clarification on policy from HHS, the NIH Director, and OER, some institutes and centers systematically [delayed funding](#) for any grants that focused on racial and ethnic minority populations, regardless of the scientific justification. To receive funding, grants were required to expand their study populations, even if the associated costs could not be justified by the scientific question or health concern. These delays lasted throughout fiscal year 2025, extending into 2026. While this hold has been lifted in some institutes, it continues in others, and a year of confusion and misguided policies has impeded or interfered with the scope of studies focused on health conditions specific to people of color.

**Termination of research addressing health disparities and health equity.** In 2025, NIH terminated more than [2,700 grants](#) addressing health disparities and/or the health of racial, ethnic, and gender minority populations. The U.S. District Court found the processes that led to these terminations illegal, a decision that the Supreme Court [declined to overturn](#). While terminations in 2026 are infrequent, more than [1,000 grants](#) terminated in 2025 have not been reinstated. The threat of terminations remains present, driving compliance with the [discriminatory](#) grant screening and censorship processes that disproportionately exclude racial, ethnic and gender minority populations from research (described in the prior section), and largely mirrors the processes the courts already found unlawful.

**Termination of research conducted internationally.** As discussed in Concern 8, the NIH suddenly and retroactively changed policies regarding foreign research collaboration in 2025, leading to the unexpected termination or disruption of ongoing clinical trials conducted abroad. Research participants, who had generously participated in science to help the health of others around the globe, were abruptly removed from medical protocols or in some cases left with unmonitored devices in their bodies in complete disregard for their [safety](#). When studies were conducted in regions lacking robust public health infrastructure, these participants were left with little recourse. This was a gross violation of ethical research standards (as discussed in Concern 3), often minimized simply because it happened beyond our borders.

**Termination of research training programs designed to broaden the research workforce.**

Based on compelling evidence demonstrating the advantages of a diverse research workforce,

and as directed by Congress in the 21st Century Cures Act ([Pub. L. No. 114-255, 130 Stat. 1033, 2016](#)), NIH developed multiple training programs to attract meritorious scientists from a variety of backgrounds. These included programs such as the Ruth L. Kirschstein National Research Service Award (NRSA) Individual Predoctoral Fellowship to Promote Diversity in Health-Related Research, which supported individualized, mentored research training of predoctoral students, and the Maximizing Opportunities for Scientific and Academic Independent Careers (MOSAIC) program, which provided 5-year awards to support postdoctoral scientists transitioning into independent faculty roles. Importantly, both programs awarded grants to highly qualified applicants identified through rigorous competition. Neither program limited participation based on any protected characteristic (e.g., race, ethnicity, sex, gender). In 2025, NIH not only ended these programs but also terminated all active grants funded under these programs, regardless of the merit, progress, or scope of the science. In the case of many NRSA awardees, NIH terminated awards to [scientists from underrepresented backgrounds](#) whose applications had received better scores than those of retained awardees who had applied via the standard pathway. In doing so, NIH [cut off](#) active health research, leaving trainees without a clear path forward in science and increasing the likelihood of these [talented individuals](#) leaving science.

## Recommendations

- **Ensure no groups, regardless of background or identity, are excluded from the benefits of NIH research.** NIH research is funded by taxpayer dollars, and thus it should benefit all Americans, including those from racial, ethnic, sexual, and gender minority backgrounds. In addition, Green Card holders (lawful permanent residents), immigrants in the United States on work visas, and the majority of undocumented [immigrants](#) all pay taxes and should be included in federally funded research. Yet, the policies and practices of this administration have systematically excluded these groups from NIH-funded research. As contributing members of the American public, these groups deserve to participate in, and benefit from, NIH research.
- **Stop the discriminatory censorship of NIH grants.** The internal “alignment” screening process must be stopped. In addition, the NIH Director must publicly acknowledge the harm caused by these discriminatory practices, apologize to those who have been excluded from research, and confirm that research will no longer be screened and censored based on discriminatory keywords. Absent a clear apology and commitment, the research community may continue to self-censor their own research.
- **Ensure all research participants, regardless of demographic background, identity or location, receive the respect, safety, and dignity they deserve** for generously donating their time and bodies to research, as also noted in Concerns 3 and 8.
- **Ensure NIH meets its statutory obligation to broaden participation in the research workforce.**
  - External [research](#) suggests a disproportionate impact of these terminations on groups already underrepresented in science. NIH should assess how grant terminations have affected the demographic makeup of NIH-funded researchers,

especially early career investigators. These data should then be shared with the public.

- NIH should reinstate prior programs and develop new programs to address persistent racial, ethnic, socioeconomic, regional, sexual orientation, and gender disparities in the research workforce, as mandated by Congress. Congress should enact measures to ensure these programs are not targeted again by future politically motivated actions.
- **Ensure NIH meets its statutory obligation to address health disparities and the health of sexual and gender minority populations**, including consideration of social determinants of health, as mandated by Congress. NIH should ensure that new agency priorities do not undermine those established and maintained by Congress for NIH.

## **Concern 3: Ignoring ethical standards has put research participants and the public at risk**

### **Why It Matters**

The early history of science was fraught with ethical violations and abuses of research participants. For example, beginning in 1932, the U.S. Public Health Service launched an observational [study of untreated syphilis](#) in Black men in Tuskegee, Alabama, without providing informed consent or disclosing diagnoses. They continued the study through 1972, well after treatment was available, causing participants to needlessly [suffer](#) neurological consequences and death, their wives to become infected, and their children to be born with congenital syphilis. This history demands that scientists remain constantly vigilant for such violations.

Motivated by these atrocities, the U.S. National Research Act commissioned the Belmont Report in 1974, which provides the foundational ethical principles and guidelines for research with human participants still used today. Adherence to the principles of the Belmont Report is codified for HHS and NIH research under [45 C.F.R. 46](#), also known as the Common Rule. These principles include:

- **Respect for persons**, which requires researchers to treat individuals as autonomous agents capable of self determination and to protect people with diminished autonomy,
- **Beneficence**, the obligation to avoid harm while maximizing potential benefits and minimizing possible risks, and
- **Justice**, to ensure fair distribution of the benefits and burdens of research.

Director Bhattacharya's NIH has violated these fundamental ethical standards, undermining the credibility of science and breaching trust with research participants and the public. Repairing this trust could take decades.

### **Examples**

#### **Abrupt clinical study disruptions created ethical issues of unprecedented scope.**

Beginning in February 2025, the Trump administration began terminating NIH research studies without warning. While termination of clinical trials is sometimes necessary, ethically [justifiable](#) reasons are typically limited to situations when preliminary study data reveal unexpected risks to participant safety, efficacy of the intervention, or futility of the study. Such terminations are also typically planned in advance, based on predetermined analyses, with clear expectations for safely closing down the study. Rather than adhering to these ethical standards, NIH prioritized political ideology by terminating [383 trials](#) affecting more than [74,000 participants](#) in 2025. The initial spate of terminations are widely attributed to DOGE, but the terminations continued under the leadership of NIH Director Dr. Bhattacharya, often at the explicit direction of Deputy Director Dr. Memoli, despite objections from NIH scientific and clinical staff. While some trials were [reinstated](#) under court order, they experienced lengthy disruptions. Many were not covered by the court ruling and remain [canceled](#). Beyond terminations, many clinical studies were delayed

for months due to uncertainty regarding “alignment with agency priorities” such as the presence of censored words or studies being conducted internationally, creating study disruptions. These terminations and delays compromised the principles of the Belmont report and, therefore, violated federal research regulations. Terminated studies, including clinical trials, were initially allowed *no time or funding* to ethically close out, safely disenroll participants, or follow through on commitments to participants. After months of harm, NIH finally changed policy to allow terminated studies to request costs to support an orderly study closeout. However, the damage caused by abrupt trial discontinuation and disruption was entirely foreseen by NIH staff and should never have occurred. These thoughtless terminations and delays created significant ethical violations, including:

- **Research participants and the public were put at unnecessary risk.** When studies were abruptly terminated or held for months, research teams were left [without funding to provide continued care](#) required by participants, such as tapering patients off medicines or monitoring implanted devices. Terminated or delayed studies were often based in countries that lacked the public health infrastructure to absorb the care of these study participants without NIH collaborations and funding. In at least one [case](#), the indefinite delay of a study on multi-drug resistant tuberculosis (TB) put the study team’s ability to continue antibiotic treatment at risk, potentially triggering further antibiotic resistance.
- **Altered risk-benefit balance, as social value decreased and risk increased.** A reasonable risk-benefit ratio is central to ethical and regulatory approval of research. This consideration may also be a primary factor for participants when they decide to join a study. Study disruptions cause incomplete data collection, making it impossible to fully answer the original research question(s) or fully realize the benefit of the research. Thus, the clinical trial disruptions decreased the social value of the study, while simultaneously placing participants at greater risk.
- **Informed consent undermined.** Study disruptions also conflict with commitments made to participants during the informed consent process, violating the respect for persons central to the ethical paradigms of science. Informed consent documents explain to participants how they can expect to be treated in the study. The informed consent guides their decision making process for joining the study. These unnecessary study disruptions forced research teams to shirk the commitments made to participants in informed consent documents, breaching participant trust.
- **Forced destruction of patient samples.** As a result of study terminations, institutions were left without funding to support the storage of human [tissue samples](#). When a participant donates tissue for research, they expect their contribution will advance scientific knowledge and benefit fellow patients. Causing the premature destruction of tissue samples donated for research through study termination undermines the participant’s altruistic intent and stymies scientific progress.
- **Erosion of trust.** Decisions to terminate studies were made without consulting study teams, undermining ethical principles of [collaborative partnership](#) and affecting the research community’s trust in NIH. Many NIH clinical studies are conducted in collaboration with members of the relevant patient community, who may serve on study advisory boards or act as members of the study team. In these cases, the erosion of

trust in NIH may extend to community partners. Indeed, a group of community research partners described their [reaction](#) to a termination letter stating that research programs like theirs “are antithetical to scientific inquiry, do nothing to expand our knowledge of living systems, provide low returns on investment and do not enhance or lengthen life or reduce illness.” The community partners said: “The majority of the patients on our [community advisory] board interpreted this message to mean: ‘Your life does not matter to us.’”

**Termination of clinical center staff continues to disrupt patient care and research.** Known as “the House of Hope,” the NIH Clinical Center is the nation’s largest hospital devoted only to research, previously attracting top research talent from around the globe. The [Clinical Center](#) focuses on trailblazing clinical research, including developing treatments where none exist, and diagnosing and treating rare or previously unknown diseases and conditions. The Clinical Center requires top-tier clinicians to support such unique and complex care needs. As a result of research interference (see Concern 1) and demoralizing working conditions (see Concern 9), world-class clinical research investigators, enormously talented staff, and patient care leaders are [fleeing](#) in droves. Many other staff, including essential nursing staff, were lost to reductions in force (RIF), probationary terminations, and [mandated 35% contract cuts](#) across NIH. The losses have become critical and threaten the hospital’s ability to operate and provide high-quality care. Tests and results are [delayed](#) due to a lack of staff. These breaches in care represent significant ethical concerns, putting patients at risk of adverse outcomes.

## Recommendations

- **Ensure all current and future NIH policy changes prioritize the health and safety of research participants and the public** over political considerations and/or speed of implementation. Prior to initiating policy changes that will affect the conduct of studies that include human participants, NIH should carry out and publish a thorough ethics review that considers the policy’s impact on respect for persons, beneficence, and justice.
- **Address Clinical Center staff shortages to ensure patient wellbeing and continuity of research.** To appropriately staff the Clinical Center, the NIH must: 1) remove contract cost limits to enable the hiring of trained nursing staff, 2) boost staff morale by acknowledging the chaos of the past 18 months and taking steps to repair the resulting harm, 3) reverse RIFs and probationary terminations.
- **Rebuild trust with research and patient communities by acknowledging, taking ownership of, and apologizing** for the harms to participants and patients caused by rapid implementation of policy changes without regard to participant safety and other central ethical considerations.
- **Ensure all research participants, regardless of demographic background, identity or location, receive the respect, safety, and dignity they deserve** for generously donating their time and bodies to research, as also noted in Concerns 2 and 8.

## **Concern 4: An unstable research environment is undermining scientific advances and public trust**

### **Why It Matters**

Instability and uncertainty are rampant across the NIH and the broader scientific ecosystem under Director Bhattacharya and Deputy Director Memoli. They have implemented radical, abrupt, and careless changes in policies related to funding opportunities, funding decisions, grant terminations, contracting, peer review, and staffing across every institute, position, and level in both intramural and extramural programs. Reduced funding, shifting policies, and political pressure hamper NIH and NIH-funded researchers. The United States faces dire consequences:

- **Reduced trust in NIH and scientific institutions.** To change policies abruptly and retroactively undermines the legitimacy of NIH. As discussed in Concern 3, this uncertainty has introduced risk to research participants, thereby damaging the public's trust in NIH. Terminating clinical studies without cause harms NIH's credibility as a steward of our nation's successful research enterprise, especially among vulnerable populations already [underrepresented](#) in research. This loss of goodwill further jeopardizes future participation in health research. Operating in a shifting landscape and under threats to their employment, NIH staff cannot effectively advise scientists on navigating NIH policies, breaking trusted relationships between program staff and the scientific community. Despite his [stated](#) desire to increase trust in science, Director Bhattacharya's actions (and inactions) have accomplished the opposite. Since Director Bhattacharya assumed his role, the public's trust in NIH [has declined](#).
- **Loss of current and future biomedical scientists.** World-class [scientists are leaving](#) the country, no longer [confident](#) in the future of U.S. science. For investigators, reduced and delayed NIH spending has created a hypercompetitive funding environment that threatens the viability of their labs, impacting employment as well as scientific progress. Funding constraints have also reduced the solvency of academic institutions, and universities have been forced to [rescind](#) offers of admission to graduate programs. Funding instability disproportionately affects early career scientists as they grapple with reduced opportunities for training and few job openings. In a 2025 National Postdoctoral Association [survey](#), more than 50% of 378 respondents reported their funding has been cut, 44% reported threats to their positions, 11% reported they had lost their jobs, and 11% reported salary or stipend freezes. Uncertainty in research funding has reached the [private sector](#) as well, with biotech and pharma losing federal grants and private investments.
- **Future therapies that won't materialize.** [Funding uncertainty](#) and reductions undermine long-term planning and momentum of successful research programs. Lack of support has forced U.S. scientists to reduce or [close](#) productive and promising research

programs. In a 2026 [survey](#) of nearly 1,000 U.S. scientists, more than 40% reported canceling planned research. Although we will never know the scientific advances that could have occurred had research funding remained stable, [projections](#) suggest funding cuts could reduce development of treatments.

- **A less-safe country.** NIH science contributes to the Nation's safety. By undermining its scientific enterprise, the United States voluntarily and incomprehensibly cedes its [national security](#), [pandemic preparedness](#), [biodefense](#), and ability to respond to public health [emergencies](#).

## Examples

**Reduced spending of NIH appropriations heightens funding uncertainty.** Director Bhattacharya and Deputy Director Memoli, with direction from OMB Director Russell Vought, have systematically implemented processes that undermine NIH's ability to disburse congressionally appropriated funds for health research, including the following:

- **New layers of justification and political approval for awarding NIH grants** are required by NIH's Office of Extramural Research. Director Bhattacharya's [Unified Funding Strategy](#) forces NIH institutes to abandon transparent funding processes based on peer review and requires staff to continue debating the merit of already-funded outstanding grant applications.
- **Disruption of grant payment systems.** The administration infamously held hostage NIH grants and contracts that were already awarded at Columbia, Harvard, and other universities to [coerce](#) these institutions into adopting policies sharply restricting free speech and academic freedom. Department of Government Efficiency (DOGE) associates prevented these institutions from withdrawing funds for active grants by [blocking disbursement](#) in the government's Payment Management System.
- **NIH mandated multiyear funding (MYF)** for 50% of all new research dollars beginning in July 2025. Most NIH grant applications are submitted with two- to five-year budgets, which are typically paid on an annual basis pending programmatic review and approval. With MYF, the entire cost of the two- to five-year award is paid in year 1. Because MYF obligates a larger portion of the annual budget to a single study, this rapid transition to MYF effectively [shrank the NIH budget](#), contributing to a [24% decline in new research](#) funded by NIH in 2025 compared to 2024 (as further discussed in Concern 6). This introduced crippling opportunity costs for new research and sowed chaos and uncertainty in the U.S. scientific workforce. While the fiscal year 2026 [NIH appropriations](#) bill constrains the use of MYF, the bill [anchors MYF](#) to fiscal year 2025 levels (about 39% of new research dollars), thus allowing comparable contraction of new research in fiscal year 2026 as we previously saw in fiscal year 2025.
- **NIH cut 35% of all contract spending** in response to [Executive Order 14210](#) in February 2025. Small biotech businesses across the United States saw their

[congressionally mandated](#) research and development contracts abruptly terminated. NIH's intramural labs found themselves with insufficient staff to care for research animals or [procure routine supplies](#). The 35% cut has introduced staffing shortages at the Clinical Center (as discussed in Concern 3), impeded critical scientific workshops, and interrupted access to critical resources for NIH laboratories.

**The threat of research terminations impedes scientific progress.** In 2025, NIH terminated [5,843](#) research grants, many for containing words or concepts the administration finds objectionable. These actions were justified post-hoc by new language in the Code of Federal Regulations ([2 C.F.R. 200.340](#)) that went into effect *after* many of the terminations occurred. Subsequent NIH [terms of award](#) force individuals and grantee institutions to agree to termination if “an award no longer effectuates program goals or agency priorities.” Previously, grant termination required evidence of ethical violations, scientific misconduct, or scientific justifications based on efficacy, futility or participant safety. Most fully funded NIH grants now remain vulnerable to full or partial termination on vague “administration priority” grounds. The threat of termination looms over all NIH grant recipients. Scientists concerned about potential termination struggle to effectively manage complex studies. This challenge is particularly acute in clinical trials, where the threat of termination introduces quandaries about the ethics of recruiting participants into a study that could be terminated on a whim (as discussed in Concern 3).

**Inexperienced, unqualified and dishonest leadership breaks public trust.** Historically, NIH leaders are selected for their scientific expertise, with only the Directors of the NIH and NCI nominated by the President. Director Bhattacharya, Deputy Director Memoli, and HHS Secretary Robert F. Kennedy, Jr., have purged respected and experienced leaders across NIH, in some cases offering [demotions](#) disguised as “reassignments” or “details” and forcing leaders into retirement. Since January 2025, the brain drain has included Ms. Julie Berko and Drs. Monica Bertagnolli, Diana Bianchi, John Burklow, Francis Collins, Gary Gibbons, Eric Green, Amy Kelley, Walter Koroshetz, Clifford Lane, Michael Lauer, Jeanne Marrazo, Kathy Neuzil, Eliseo Perez-Stables, Tara Schwetz, Larry Tabak, Shannon Zenk, and many other trusted, respected, and eminent scientists and administrators.

None of them have been replaced with people of equivalent stature. Replacements such as Seanna Cranston, Rachel Riley, and James McElroy have arrived with minimal-to-no experience in science, health care, or health administration. Some NIH institutes installed politically aligned individuals in newly invented positions, such as Chief Operating Officer (COO) or Chief Science Advisor (CSA). In October 2025, during the government shutdown when hiring processes are normally on hold, NIH removed the Director of the National Institute of Environmental Health Sciences and replaced him with Kyle Walsh, the [former roommate and friend](#) of Vice President Vance. In at least one case, this directly *increased* waste, fraud, and abuse at NIH, at least temporarily. Within 3 months of his appointment, Eric Schnabel, NIH's COO plucked from the defense industry, was [investigated and fired](#) after NIH awarded a contract to an entity that employed his wife.

Newly appointed HHS and NIH leadership have actively eroded trust in NIH and American science and risked the well-being of the American public. HHS [Secretary Kennedy](#) has spread dangerous misinformation on public health, which has not been refuted by Dr. Bhattacharya in his roles as either the NIH Director nor Centers for Disease Control and Prevention's Acting Director. In his first NIH staff town hall, while trying to rationalize major shifts in agency policy and practice, Director Bhattacharya [accused](#) NIH of causing the COVID-19 pandemic. He has continued to promote one-sided COVID-related conspiracy theories through the so-called [Scientific Freedom Lecture Series](#), ironically described as promoting "the principles of gold standard science." Despite ample [evidence](#) on the impact that structural racism has on minority health and health disparities and validated approaches to [measure](#) the phenomenon, Director Bhattacharya continues to [insist](#) that structural racism is not a legitimate line of research. Director Bhattacharya has also repeatedly [obfuscated](#) the state of NIH operations, providing dishonest representations to Congress and the public. In short, positions of authority and accountability at NIH are increasingly filled by people who lack the technical knowledge or integrity to make sound decisions about the future of health research in the United States.

## Recommendations

- **Ensure NIH staff are able to maximize the benefit of congressionally approved appropriations.** NIH must lift mandates that have impeded the ability of its staff to ensure funding is spent in the best interests of the American taxpayer. NIH, HHS, and OMB should reduce layers of political oversight that undermine peer review standards and drastically slow down processes. NIH should rescind the multiyear funding mandate that reduces the power of the NIH budget. NIH should ensure that all of its operating divisions can individually justify contracts based on needs rather than an arbitrary cap. If NIH, HHS, and OMB fail to address these issues, Congress should enact meaningful guardrails to ensure the Article 1 Branch maintains the power of the purse, as directed by the U.S. Constitution.
- **Ensure future grant terminations only occur when justified** by scientific or ethical concerns, such as study futility, early determinations of efficacy, unexpected participant harm, or investigator misconduct, as noted in Concern 1. The threat of study terminations creates substantial uncertainty that impedes the ability of scientists to conduct their research.
- **Introduce new policies with clarity, transparency and reasonable implementation time frames.** Allow broad scientific input before proclaiming NIH priorities. Adhere to the [Administrative Procedures Act](#) and resume best practices of incorporating input from NIH scientists and the scientific community regarding research priorities, established through workshops, working groups, scientific conferences, requests for information (RFIs), and other methods. Thoughtfully examine existing mechanisms and processes before implementing new policies. Introduce new policies to NIH staff before public dissemination. Provide clear and rational guidance and processes to inform NIH staff and the public. Consult scientific experts and individuals with lived experience regarding: a) health disparities research, b) workforce diversity, equity, inclusion, and accessibility, c) COVID-19, long-COVID and immunizations, d) climate change, e) gender and intersex

populations, f) foreign collaborations, and g) animal research. Recognize that specialists at NIH and elsewhere can bring their experience, not to discourage, but to enhance the success of, new initiatives.

- **Develop and restore funding mechanisms that support training to counteract brain drain.** NIH must act urgently to counteract the substantial reduction in opportunity for early career scientists. Allow program staff to develop and strengthen funding opportunities to support training of clinical and basic scientists. New programs must accomplish the goals and adequately replace previously successful training programs that were terminated. This will require flexibility in the development of funding opportunities, without arbitrary limitation in the number of opportunities. In addition, Congress must establish clear, meaningful, and binding protections against the disruption of these critical programs in the future.

## **Concern 5: Lost critical expertise is hindering the NIH mission**

### Why It Matters

As of April 2026, NIH [lost over 4,400 employees](#) since January 2025 through probationary firings, reductions in force (RIF), incentivized retirements, staff resigning in protest or under pressure, alongside usual departures, representing a reduction of roughly 20% to 25% of its total workforce. Contract terminations and non-renewals have further reduced capacity. In many cases, cuts were made arbitrarily and without consideration of how key job functions could still be accomplished by remaining staff. Cuts targeted critical areas such as workforce management, legislative affairs, communication, and ethics, among many others. NIH's expert workforce management staff identified, trained, and managed the scientific leaders of our nation. Communications staff helped share NIH research findings with the public. Ethics staff ensured adherence to ethical guidelines. Policy staff enabled effective communication with Congress. The reductions in mission-critical personnel has significantly impeded NIH's ability to achieve its stated [priorities](#). The mission of NIH, to seek fundamental knowledge and apply that knowledge to enhance health, lengthen life, and reduce illness and disability, cannot be achieved without the foundation of the individuals who sustain it.

Specifically, the planned and actualized staff reductions led to losses in:

- **Irreplaceable knowledge and institutional memory.** RIFs removed entire offices and divisions from NIH, leaving little or no staff in certain mission areas. With almost no one remaining in these areas, certain areas of expertise and knowledge of past practices are no longer available to the agency
- **Novel perspectives, emerging scientific expertise, and future leaders.** The termination of probationary employees categorized as new hires or recently promoted personnel deprived NIH of scientists and related professionals capable of advancing both the agency and the wider scientific community. These dismissals effectively suppressed the introduction of novel ideas and innovative scientific methodologies. Since recently promoted staff constituted some of NIH's most exceptional talent, these actions severely impacted the cultivation of future agency leadership.
- **Undermining relationships with scientists and community partners.** These professional relationships were formed through years of outreach and collaboration. The sudden nature of the terminations left no time for proper communication and orderly transition, jeopardizing any future partnerships.
- **Ability to carry out NIH's most basic functions.** Personnel reductions among critical grants management staff have compromised the capacity of NIH institutes [struggling](#) to evaluate research proposals, manage funding allocations to external research institutions, and issue research grant awards. As discussed in Concern 3, termination of Clinical Center staff continues to endanger patients and disrupt research.
- **Transparency and trust.** RIFs removed roles related to information sharing with the public and Congress, including communications and legislative affairs offices as well as

staff who processed Freedom of Information Act requests, a primary tool for the public to understand government actions.

These losses will be exacerbated by the OMB [Schedule Policy/Career](#) rule, which was designed to strip career civil servants of their employment protections by making positions “at will” and enabling the executive branch to fire staff for political reasons and without performance-related cause. The new category classifies positions that “help shape or carry out Presidential policies, or involve a high level of confidentiality or policy influence” and was [intended](#) “to enhance accountability in these policy-influencing positions.” However, the White House’s list of [NIH job classes](#) to be designated Schedule Policy/Career includes frontline staff and managers (e.g., Health Scientist Administrators, Branch Chiefs) involved in regular scientific administrative work. Civil service protections were designed to stop the “[spoils system](#),” wherein the elected party rewarded its supporters with government jobs. Removing civil service protections will increase [political pressure](#) on government career professionals, exacerbating the ongoing brain drain, increasing grant funding barriers, and furthering the discriminatory practices described in Concern 2.

## Examples

**Firing staff responsible for public and congressional communications undermines stated goals to rebuild public trust in NIH.** Through dismissals and reorganization, individual institutes and centers have been left without dedicated communication teams. A consolidated central communications office cannot have all the information needed to provide accurate and up-to-date information about advances in every health area in the NIH mission. This limits NIH’s ability to inform the public about taxpayer-funded research outcomes and counter false information about NIH and the science it funds. The same winnowing and reorganization has negatively impacted policy and legislative functions; staff with critical institute-specific expertise are no longer available to answer urgent legal and congressional inquiries.

**Widespread vacancies in institute and center directors and senior staff.** With the change in administration, NIH lost 17 of 27 Institute and Center Directors, and 14 directorships remain vacant. In some institutes and centers, gaps in permanent leadership extend to the division level. Reassignment of senior staff as detailees to other institutes adds further concerns about the functional stability of NIH. As a result, the ability to develop institutional goals, plan long-term priorities and provide guidance to a highly concerned research community has been crippled.

**RIFs were executed without understanding of staffing needs.** RIFs were based on broad position codes, without evaluation of component roles. Entire human resources (HR) branches were let go based on alphabetical order (e.g., Branches A-E) without regard to responsibilities. As a result, the RIFs eliminated all HR for some institutes and centers, as well as the entire NIH-wide retirement office, leaving some parts of NIH without HR staff to support ongoing incentivized retirement programs and other staffing changes. Moreover, the lack of transparent communication and the targeting of specific sectors, like HR and administrative officers (AO), impeded staff from carrying out basic job functions that led to widespread confusion about roles,

responsibilities, and who remained to do the work. Demonstrating clear continuing need for some RIFed positions, Contracting and Acquisitions staff, who provided for the purchase of office and research supplies, research and development contracts, information technology contracts, and other needs, were asked to continue to work while on administrative leave after receiving RIF notices. Despite their continued service and demonstrated need, most were separated from federal service and let go on Monday, July 14, 2025.

**Regulation-driven, statutory, time-limited and essential activities are stalled.** Absent staff with the necessary training and skills to complete them, NIH functions required by law, such as review of contract deliverables and invoices, Paperwork Reduction Act clearances, pre- and post-award administration of grants, and timely responses to congressional inquiries, are being conducted without appropriate expertise. For example, probationary terminations and incentivized retirements substantially reduced grants management staff at many institutes, [impeding](#) NIH's ability to award grants. The shortage of grants management staff has become so [severe](#) that one institute estimates that under current staffing levels, they could issue only about 5% of its typical new awards, potentially leaving \$500 million unspent. At another institute, property management staff were RIFed, and the upper managers who have assumed responsibility for oversight of government property are unfamiliar with how the electronic systems work. As a result, staff whose laptops were broken could not obtain new ones. The fulfillment of Freedom of Information Act requests has been distributed across staff, taking time away from science, grants management, and other critical activities.

**Insufficient oversight of high-risk studies and clinical trials.** Lack of staff with clinical knowledge and expertise can lead to safety and productivity risks. Over the last 18 months, NIH has [lost](#) dozens of clinically-trained scientists responsible for the oversight of high-risk projects, such as drug and device-based interventions in children and patients with advanced or rare diseases. This reduction in clinical staff presents ethical challenges including endangering research participants, as discussed in Concern 3.

**The talent pool for NIH staff has been curtailed.** The American Association for the Advancement of Science (AAAS) fellowship program, Presidential Management Fellows (PMF), and other fellowship and internship opportunities have been discontinued. This disrupts long-standing pathways to NIH employment and blocks NIH from the benefits of working with creative young scientists (and non-scientists) who represent the future of the U.S. health research enterprise. In addition, [reporting](#) suggests that the dismissals of NIH employees, which targeted workforce management, scientific administration, financial management, and communications, likely disproportionately impacted people from racial and ethnic minority groups. The OMB has removed race and ethnicity from their published workforce data, undermining the ability to monitor disparate effects. This reduction in diversity diminishes the ability of NIH to serve all Americans.

## Recommendations

- **Bring NIH staffing back to appropriate levels to enable mission-critical work**, including communications, workforce management, human resources, legislative affairs, and other domains targeted by RIFs. Hiring excellent and needed staff will require restoring the reputation of the NIH working environment, which is widely recognized as hostile, as discussed in Concern 9. Rehire RIFed employees and probationary employees, where possible. Conduct a careful review of institute- and center-specific staffing needs, and restore staff with specific expertise in acquisitions, communications, legislative affairs, planning and evaluation, and other staff areas that were targeted by consolidations. Restore staff support for NIH's internal laboratories, including administrative operations, purchasing of laboratory supplies, hiring of needed personnel, and management of lab facilities, so that labs run efficiently and scientists can pursue science rather than paperwork.
- **Protect the NIH mission by ensuring career civil servants retain employment protections** and cannot be fired for political reasons, as would be enabled by the recent implementation of the Schedule Policy/Career designation. Congress must ensure that NIH staff have access to the full benefit of civil employee protections, so they continue to be hired and retained based on merit and not political views.
- **Fill vacant institute and center directorships with qualified scientists** selected through the search process [typical](#) at NIH prior to 2025. Congress should establish binding [requirements to ensure](#) rigorous search processes for these directorships, such as mandating search committees composed of both internal civil servant staff and independent external scientists and requiring a minimum time period for posting job announcements.
- **Address Clinical Center staff shortages to ensure patient wellbeing and continuity of research**, as recommended in Concern 3.
- **Reinstate fellowship and training programs that provide a pipeline of excellent NIH staff**, such as the AAAS fellowship program and PMF program.

## **Concern 6: Changing policies without staff input is creating foreseeable damage**

### **Why It Matters**

Institutional expertise is an essential component of organizational success. It is an asset that any competent management team must deploy for effective and prudent stewardship of available resources. This is particularly true at NIH, because the consequences of ignoring institutional expertise can endanger lives. In addition, the ecosystem of NIH grant funding is large and complex because it must address a wide variety of needs for the health research enterprise. These include filling research gaps with specific funding opportunities and projects, supporting shared research resources and infrastructure, training the research workforce, and supporting entrepreneurship through the small business programs. As such, developing and implementing effective policies at NIH depends on institutional knowledge that cannot be improvised. The staff who implement, administer, and oversee this ecosystem carry decades of scientific and administrative experience.

Since January 2025, Director Bhattacharya, HHS, DOGE, and OMB have in multiple instances envisioned, developed, and implemented changes without staff input, forcing staff to execute flawed and often conflicting policies that cause harm. These instances involve political disruption of peer and programmatic review without staff consultation, even though peer review is mandated by the Public Health Service Act ([42 U.S.C. § 6A](#)). This has led to extensive delays, termination or non-awarding of grants for health research, disrupting taxpayer investments intended to benefit the American public. The cost of the mismanagement of NIH's best asset—its trained and experienced staff and consultants—is uninformed decisions, foreseeable error, and inconsistent or inappropriate implementation of policies. Such exclusion of institutional knowledge inevitably results in foreseeable harm as well as wasted time, effort and resources. The ultimate impact of this mismanagement falls disproportionately on those least able to weather it, such as patients and participants in abruptly terminated studies (as discussed in Concern 3) and early career scientists losing funding just as their work begins to bear fruit (as discussed in Concern 4). In biomedical science, technology development and human health, the consequences of these process failures are catastrophic.

### **Examples**

#### **Termination appeals denied without (or against) Scientific Program Officer consultation.**

When grants were [terminated](#) under new policies and practices beginning in 2025, grantees were able to submit an appeal to justify the merit and appropriateness of their science. These appeals were seldom successful, and were often denied without input from relevant scientific staff. When input from relevant staff was sought, it was often disregarded. Disregarding the scientific judgement of scientific staff with appropriate expertise has been a common practice under Director Bhattacharya, as discussed in Concern 1.

**III-considered changes to the management of peer review.** Over the last 18 months, a [number of changes](#) have been imposed on the peer review process at NIH, without the input of knowledgeable peer review staff. These changes include [consolidation](#) of institute and center peer review branches into CSR, which impedes nuanced review of specific funding opportunities tailored to address the unique needs of the research communities supported by individual institutes and centers. In addition, NIH no longer requires study sections to reflect “diversity with respect to the geographic distribution, gender, race, and ethnicity of the membership,” despite [statutory](#) requirements that such committees be balanced with respect to the U.S. population. Changes to the Early Career Reviewer program eliminating smaller workloads designed to enable junior investigators to more easily transition to full-scale review may impede participation in peer review by this next generation. The [termination or reduction](#) of benefits to scientists who volunteer on advisory committees and study sections, including the elimination of continuous submission and the narrowing of the window of qualifying service for late submission, undermines service in peer review and impedes the recruitment of reviewers. In addition to these policies being implemented without staff input, these changes occurred without expert input from the Center for Scientific Review Advisory Council that would typically offer guidance to the director of CSR, because the council was recently disbanded. The [cumulative effect](#) of these changes undermine rigorous and fair peer review of research applications submitted to NIH.

**NIH mandated a 50% rate of multiyear funding (MYF) without staff input.** As discussed in Concern 4, MYF pays the full cost of a grant award upfront, [reducing](#) the impact of the NIH budget. In addition, MYF reduces the ability for NIH staff to effectively oversee awards, as further funds cannot be withheld should studies fail to achieve study objectives or reach critical milestones such as adequate participant recruitment. The MYF mandate has also been particularly damaging to clinical trials. NIH is not considering clinical trials for MYF because they involve human study participants and require annual oversight for safety and productivity. Because these studies still count against the 50% directive, clinical trial applications face the dual obstacles of funding decreases and de-prioritization of non-MYF awards. This may lead to a decrease in federal investment in clinical trials, which seek to bring new therapies and treatment approaches to patients with chronic and life-threatening diseases.

## Recommendations

- **Solicit input from staff with relevant experience and knowledge before adopting any new policy or processes.** NIH staff understand the consequences of process change and can identify foreseeable harms before implementation. Routine incorporation of staff input, through working groups, pilot testing and structured review, would prevent many of the avoidable disruptions documented in this report (Concerns 4, 6 and 7).
- **Ensure new policies are deployed with appropriate support, training, and mechanisms of adequate implementation.** Policies implemented on extremely rapid timelines, without staff consultation or preparation, are bound to produce unnecessary disruption and harm.

## **Concern 7: Cumbersome and shifting processes are wasting resources and harming health**

### Why It Matters

Some who have reached government via Silicon Valley suggest that moving fast and breaking things enables innovation, but the approach can have serious adverse consequences, especially when applied to clinical research where human health, safety, and lives are at stake. NIH is not a startup; its mission represents a compounding investment where the returns depend on stability. Effective scientific administration benefits from stable, predictable, and proportionate processes.

Yet, under HHS Secretary Kennedy and Director Bhattacharya, NIH has imposed arbitrary, ill-conceived, and cumbersome administrative burdens. These have often been launched abruptly without preparation, support, training, or mechanisms for adequate implementation. In some cases, policies are reversed, revised, and altered multiple times within mere weeks, creating uncertainty, instability, and waste. When administrative requirements are poorly thought through, implemented without adequate preparation or expert input (as discussed in Concern 6), or changed repeatedly without adequate notice or guidance, unnecessary costs fall on the shoulders of NIH staff, scientists, and the public. Derailing the careers and research pathways built with NIH funding represents an enormous self-inflicted waste of technological and scientific capacity, all to the detriment of American innovation and health.

### Examples

**Escalating administrative burden on program officers and principal investigators.** Many of the administrative policies being implemented suffer from flaws, inconsistencies, and contradictions, requiring continual changes in methods and processes. The increased burden from these shifting policies undermines NIH staff's ability to carry out mission critical activities. Every hour a grants manager, program officer, review officer, or scientist spends navigating the shifting and erratic changes in policy and bureaucracy is an hour not spent advising investigators, identifying scientific gaps, enabling peer review, or advancing research. Cumulatively, the time and effort lost to implementing and correcting flawed policies delays discoveries and wastes taxpayer investment. In addition, increased burden without benefit drives staff attrition and lowers the attractiveness of the federal government as an employer, exacerbating staffing problems (as discussed in Concern 5). Examples include:

- **A cumbersome screening process for ideological alignment has slowed the pace of grant awards.** As discussed in Concern 2, the screening process uses a [“computational text analysis tool”](#) to scan for a discriminatory set of terms, flag grants as “misaligned” with new administration priorities, and launch scientifically unnecessary cycles of “renegotiation.” The time required to manage active NIH grants has increased significantly, forcing staff, grantees, and institutions to focus on paperwork rather than

fostering good science. Moreover, this lengthy process risks NIH's ability to obligate its Congressionally appropriated funds before the end of the fiscal year, as required by law.

- **Barriers to supply procurement interrupts access to critical lab resources**, impeding cutting edge and unique intramural NIH research. All purchasing orders above \$15,000 now must go through a lengthy, centralized process that takes so long it effectively functions as an arbitrary limit on essential laboratory tools and resources. Backlogs and arbitrary deadlines being imposed for purchase orders further impede obtaining needed equipment and resources, including inability to purchase new instruments and a lack of instrument service contracts to maintain and/or repair current instruments.
- **Idiosyncratic travel policies interrupted critical work.** These shifting policies prevented scientific staff from exchanging knowledge at conferences and program staff from overseeing NIH scientific investments. In early 2025, travel was almost entirely banned. [Travel policies](#) were changed multiple times in a year, with seemingly arbitrary approval or disapproval from political appointees, changes in advance notice, and procedures.
- **Changes to performance evaluations**, an annual regulatory requirement for NIH staff (5 CFR 430.201–430.210), were implemented off cycle, temporarily halting the entire process. These changes doubled the time required by supervisors and employees to complete the appraisal process, while restricting the range of evaluation outcomes.

**Three policy changes on foreign subawards in rapid succession, with no scientific rationale.** The disruption to foreign subawards, discussed in Concern 8, illustrates how policy changes waste the resources of both NIH staff and the investigators they support. On May 1, 2025, NIH [banned](#) all foreign subawards. Less than three months later on July 18, 2025, when the fully predictable impact and harms of abrupt trial terminations occurred, NIH [created](#) a limited mechanism to maintain foreign subawards for grants involving human research participants. The “[final](#)” policy announcing the PF5 multi-project award, released in January 2026, was followed by two more modifications. This PF5 mechanism represents a more complex, burdensome, administrative structure for investigators and NIH staff alike, requiring separately managed project components with distinct budgets, timelines, and reporting requirements. These abrupt and repeated changes required program officers across NIH to assess and reassess foreign grant components, contact and recontact affected investigators, and determine again and again whether and how those components could be restructured or terminated. For investigators, the changes required immediate removal of international collaborators, who in many cases provided unique expertise, equipment, data, or patient populations, from funded projects. The cumulative effect has been a significant waste of administrative labor: program officers, grant managers, and investigators were required to analyze their portfolios, notify collaborators, modify grant structures, and prepare documentation at least three times in response to shifting requirements. Scientists abroad who had been removed from U.S. grants, sometimes disrupting multi-year studies at critical stages, could not simply be reinstated. Some collaborations were permanently lost. The scientific investments embedded in those partnerships, funded by years of prior NIH awards, were partially or wholly forfeited.

**The waste of terminated science.** The costs associated with the loss of value, scientific knowledge, technological capacity, and lives resulting from termination of NIH grants will likely never be accurately established. As discussed in Concern 1, NIH [terminated 5,522 grants](#) in 2025. Each terminated study may be a cure or technology that will never manifest, and each abandoned study participant is a person left without hope. Terminating a grant or contract before it can deliver results does not “save costs;” it throws prior funding down the drain. What we know is that the costs are large and growing, and the current lack of respect for patients, study participants, staff and taxpayer dollars needs to end.

## Recommendations

- **Eliminate unnecessary and redundant layers of political review and justifications.** After two levels of review for scientific merit, evaluation of relevance to the institute or center’s mission by program staff, and financial and policy review by grants management, the addition of non-scientific and political layers of review introduces political bias, unnecessary process and wasted resources. The costs (in dollars, time, lives, and public health) of any new policy must be estimated and considered *before* deployment.
- **Issue transparent, publicly available guidance.** Researchers and the majority of NIH staff do not have access to the criteria (if any) that determine travel approvals, enable timely purchase of laboratory equipment and resources, or inform which grants get terminated, flagged or approved. Similarly, the evolving list of “misaligned terms” that will trigger “renegotiation” are not provided to most staff or the public. The inconsistency and lack of transparency wastes time, energy and resources.
- **Return decision making authority to experts (e.g., program officers, scientific review officers, grants management staff) with the appropriate statutory guardrails.** These staff are charged by law with stewarding public funds for science, and possess the relevant scientific and administrative expertise to do so. This recommendation includes safeguarding the input of NIH scientific staff with expertise in relevant research areas on funding decisions, as recommended in Concern 1. Restoring their delegated authority, proven through the years to be productive, effective, and accountable, will significantly reduce waste and opportunities for abuse.
- **Conduct and publish an audit of the administrative costs, liabilities accrued, and expertise lost as a result of the turbulent 2025-2026 policy changes.** Transparent accounting of wasted expenditures and efforts, participant harms, legal liabilities, lost capacity and institutional knowledge at NIH (and across the nation) will document the true cost of the “move fast and break things” approach and inform targeted corrective action. Congress should commission the Government Accountability Office, as a trusted independent entity, to produce and disseminate such analysis.

## **Concern 8: Disruption of global research is endangering people in the United States and around the world**

### Why It Matters

Global collaboration allows the scientific enterprise to transcend national borders and benefit from scale. Without meaningful international collaboration, NIH risks funding science that reflects a limited view of the most pressing health challenges facing research and patient communities. Research partnerships have always been critical to identifying cross-cutting scientific priorities and leveraging complementary expertise across research teams and national boundaries. Barriers to collaboration create roadblocks to developing solutions that are scalable, adaptable, and generalizable. International collaboration brings significant benefit to the U.S. scientific enterprise and the American public:

- **Global scientific advances benefit the American public.** Research conducted internationally with [NIH funding](#) greatly enhances understanding of and treatments for American health challenges including [heart disease](#), [Alzheimer's disease](#) and [diabetes](#).
- **International disease models aid development of guidelines for healthcare in the United States.** American startups and small businesses leverage global technology development. Global research helps ensure that research and treatments are reliable and reproducible. Basic, translational, and clinical research conducted outside of the United States improves our ability to identify and treat diseases among Americans, including service members deployed during peacetime or conflict.
- **Infectious diseases do not respect international borders.** Our planet's ecosystem is mobile and dynamic. Some diseases not common in the United States may be contracted and brought home by [travelers](#), as occurred during the COVID pandemic. The current Ebola outbreak is a timely reminder of this concern, though the risk to people in the United States remains [low](#). In southern U.S. states, mosquitos increasingly transmit diseases such as malaria, dengue, zika, chikungunya and yellow fever that were not historically common in the United States. Due to climate change, the range of insects that carry these diseases are [expanding](#) in the United States, increasing rates of vector-borne disease. To protect Americans against future illness and death from infectious diseases, current research must be conducted where the diseases and disease-borne vectors exist now. Global science collaborations are critical for bringing evidence learned in the United States directly to people where an infectious disease (e.g., malaria) is more common.
- **Rare diseases are difficult to study without including patients from around the world.** Due to their low prevalence, rare diseases [require](#) global collaboration to conduct meaningful research. Often, the United States does not have enough cases of a rare disease to enable valid research to support biomarker development and treatment solutions. Rare diseases also require specialized expertise that is often [scattered](#) across the globe.

- **Health care innovations are not limited to the United States.** By engaging with researchers and health care workers in many countries, we can leverage innovations from other countries to improve U.S. healthcare. For example, the [NIH Global Health Reciprocal Innovation](#) project aims to explore how reciprocal innovation can help spread and scale health technologies, methodologies and strategies from low- and middle-income countries to address similar challenges in other regions, especially high-income countries. The [International Cancer Benchmarking Research Partnership](#) aims to measure, understand, and address causes of global differences in cancer incidence, survival, and death. Many studies leveraging global collaborations have led to key medical advances, including the [Point-of-Care Research Technology Network \(POCTRN\)](#).
- **NIH already had strong protections in place for oversight of research taking place outside the United States.** NIH has long monitored "foreign components" in grant applications and awards. These foreign collaborations are well documented by program staff and many require State Department clearance. In response to a 2023 GAO report, NIH furthered its oversight on foreign components, updating its Grants Policy Statement to increase oversight of subaward agreements and adding a validation step to require progress reports prior to funding.

## Examples

**Foreign collaborations have been interrupted and discouraged.** On May 1, 2025, with no advance notice or opportunity for staff or public comment, NIH banned foreign subawards in all new and non-competing NIH grants, forcing scientists to remove long-standing collaborators from their grants [NOT-OD-25-104]. Some research projects were required to remove the foreign component entirely. For example, the [Cancer Intervention and Surveillance Modeling Network \(CISNET\)](#) was stopped, then redesigned, ending long-standing international collaborations. Other studies were able to change the foreign component into a supplemental award. Many faced termination. For clinical trials conducted abroad, this represented a substantial ethical concern, as discussed in Concern 3. Even though these concerns were easily foreseeable, it took NIH more than three months to release a new announcement ([NOT-OD-25-130](#), July 18, 2025), creating a limited mechanism to maintain foreign subawards for grants involving human research participants. For nearly a year after the initial policy change, U.S. scientists not conducting clinical studies had no avenue to apply for grants with their non-U.S. collaborators [[NOT-OD-25-104](#); [PA-26-002](#)]. While NIH now has a funding announcement for such collaborative projects that restructures foreign partners as direct NIH-administered components ([PA-26-002](#)), many previously funded and valuable international collaborative projects, including CISNET, do not fit its requirements. Further, the new mechanism is not expected to make its first awards until spring 2027, nearly two years after foreign subawards were banned. In addition, some countries are subject to a *de facto* ban on funding, despite the absence of any internal policy or public announcement. Prohibited countries are not shared publicly and may change without notice.

**Foreign scientists in the United States are working in an increasingly hostile environment.** International scientists are a critical part of scientific excellence in the United States. More than 30% of all Nobel laureates since 2000 solely affiliated with a U.S. institution were [foreign](#) born. Yet, the administration has [intimidated](#) foreign scientists at U.S. ports of entry, harassed and [detained](#) foreign scholars, and established higher barriers for visas, permanent residency and citizenship. Together, these policies have reduced enrollment of international students at U.S. institutions [by 17%](#), striking a severe blow to the United States' most important trade balance asset, education. NIH has not been exempt from this hostility. Two leading infectious disease researchers, citizens of the Netherlands and Cameroon, were recently [arrested](#) in what has been described as “a political witch hunt.” The brain drain of early-stage researchers, the next generation of scientists, as well as more experienced investigators is ongoing, with unpredictable consequences for the competitiveness of U.S. science and technology.

## Recommendations

- **Keep research international.** Upon completion of training, many foreign scientists elect to stay in the United States and contribute to the biomedical research enterprise here, some return to their home nations to collaborate and share what they've learned. This is a win-win situation for the United States. Blanket restrictions on foreign collaboration based on nationality should be removed. Effective coordination with the U.S. Department of State and the Fogarty International Center should be implemented to streamline the visa process for trainees for the duration of their training period and for post-doctoral and early-stage investigators to allow them to remain active as they develop their research careers. To keep its leading international position, the U.S. scientific enterprise must continue to draw talent from around the world.
- **Ensure all research participants, regardless of demographic background, identity or location, receive the respect, safety, and dignity they deserve** for generously donating their time and bodies to research, as also noted in Concerns 2 and 3.
- **Reaffirm NIH support for global collaboration**, which helps the United States remain a leader in biomedical research.
- **Provide NIH applicants and staff with appropriate guidance and instructions for the new PF5 mechanism for NIH funded international collaborations.** While some useful information has been provided, both applicants and staff need more information on this new grant mechanism.

## **Concern 9: A culture of fear and low morale is eroding scientific integrity**

### **Why it Matters**

Despite Director Bhattacharya's frequent emphasis on the value of scientific dissent and transparency, **NIH has become a hostile work environment marked by [fear and low morale](#)**. This environment was created from the beginning of the Trump administration and the arrival of the Department of Government Efficiency (DOGE) in January 2025 and [continues to this day](#).

Creation of this hostile work environment is intentional and perpetuated by leading government officials. Regarding federal employees, OMB Director Vought stated: "When they wake up in the morning, we want them to not want to go to work, because they are increasingly viewed as the villains. We want their funding to be shut down ... [We want to put them in trauma](#)." Department of Health and Human Services Secretary Kennedy disparaged public health officials, saying "[Public health agencies have not been honest](#)." Secretary Kennedy also [said](#) that public health authorities should not be trusted, because "trusting the experts is not a feature of science or democracy, it's a feature of totalitarianism and of religion." Threats made to federal workers as well as actual harms, including the [attack at the Centers for Disease Control \(CDC\)](#) in Atlanta, may have been inspired by such villainization.

NIH Director Bhattacharya has also contributed to the low morale of employees by [publicly stating](#) that NIH has failed its mission and has lost public trust. He suggests that NIH staff are the cause of this alleged loss of trust, with no evidence or acknowledgement of how disinformation, factions, and political doublespeak have [eroded](#) trust. He [obfuscates](#) when asked about policies and practices that harm staff and their ability to encourage innovative, rigorous, and impactful research. In fact, Dr. Bhattacharya himself [bears partial blame](#) for the loss of trust in NIH. As Josh Bloom and Henry Miller [said](#) at the time of his nomination, "[Bhattacharya's] flawed views led to unnecessary suffering and eroded trust in science." Indeed, trust in NIH has [declined](#) since his arrival. Devaluing his staff's scientific expertise and dedication to the highest standards, Director Bhattacharya has sought unearned recognition for implementing "[gold-standard science](#)," when in fact, NIH has always conducted and supported the highest quality, peer-reviewed research.

This hostile work environment:

- **Saps employees' energy and enthusiasm**, threatening their ability to effectively carry out their duties and detracting from the NIH mission.
- **Creates fear resulting in reduced collaboration, mistrust among colleagues, self-censorship, and "anticipatory obedience,"** as Discussed in Concern 1. The fear of speaking up in the face of waste and abuse is detrimental to the safety of patients, progress in science, and the health of the American people.
- **Contributes to brain drain from NIH**, as discussed in Concern 5. The mass [exodus](#) of experienced and excellent staff has created a loss of scientific and administrative

expertise, institutional memory and experience-based knowledge. This includes departures of high-profile leadership with [no explanation or farewell messages](#), some of whom had been targeted by the [“DEI Watch List.”](#)

Abundant historical examples demonstrate that a culture of fear adversely affects science. For example, the Soviet Union’s [“Lysenkoism,”](#) wherein scientists were suppressed and persecuted, led to disastrous, famine-inducing agricultural policies. A culture of fear is antithetical to freedom of inquiry, which is necessary for conducting and funding rigorous and reproducible science.

## Examples

**Retaliation and targeting create a culture of fear.** Although Dr. Bhattacharya [professes](#) to support unimpeded academic freedom and has made assurances not to retaliate against NIH staff for public dissent, his and the administration’s actions towards NIH staff have not reflected these stated values. Early in 2025, memos from senior HHS leaders and unnamed HHS listservs set a tone of fear, for example by encouraging NIH staff to report on their colleagues for any ongoing DEI activities. Former institute and center directors [Jeanne Marrazzo and Kathleen Neuzil](#), who wrote a whistleblower report to Congress, were placed on administrative leave and later [fired from NIH](#). Over half of NIH institute and center leadership were dismissed, as well as many other excellent scientists and leaders across NIH, as discussed in Concern 4. In conjunction with public retirements of [NIH workers](#), these purges showcase the significant environment of censorship, retaliation and low morale.

Bethesda Declaration signers have also experienced retaliation, including receiving censures from their superiors and being targeted with Freedom of Information Act (FOIA) requests from outside groups. Dr. Jenna Norton, a lead Bethesda Declaration organizer was [abruptly](#) placed on administrative leave for more than 5 months without any official explanation. However, an anonymous HHS official [defamed](#) her as a radical leftist claiming she was put on leave because she was criticizing the administration, and Director Bhattacharya [falsely claimed](#) she had previously been investigated by the NIH. Though NIH [reinstated](#) Dr. Norton in May 2026, NIH failed to acknowledge and be accountable for its actions. At sister agencies like [FEMA](#) and [EPA](#), employees were put on leave after signing their own letters of dissent. Some were also [reinstated](#) in May.

The culture of fear may be heightened via OMB’s recently implemented [Schedule Policy/Career rule](#), as described in Concern 5. By removing civil employment protections from scientific grant-focused staff and civil servant managers such as Branch Chiefs and Division Directors, all staff continue to navigate uncertainty and the strong possibility of losing essential NIH colleagues. Such conversion of NIH career staff to “at-will” status undermines the independence of thought and sense of safety that enable honesty and excellence in the oversight and review of scientific grants and funding.

**Disruptions to productivity reduce morale.** As detailed in Concern 7, policy changes now routinely occur without input from staff. New policies are communicated poorly, sometimes not even in writing, leading to spotty and variable awareness, interpretation, and enforcement.

Similarly, unprecedented numbers of legal challenges and rulings against the administration's policies are followed by a lack of guidance on the implications of rulings.

As discussed in Concern 5, the loss of skilled scientists, grants management, administrative staff and other trusted colleagues through dismissals of probationary staff, reductions in force, and voluntary departures affects morale as well as efficiency, as staff need to to adopt shifting responsibilities. Added duties often overwhelm those who remain, who may lack expertise, training, or bandwidth for these new tasks.

Limitations and cancellations of NIH-led initiatives like [Notices of Funding Opportunities \(NOFOs\)](#) send a message to scientific staff that exploring and championing specific areas of science, which they were hired to do, is no longer a priority.

Despite the [benefits](#) of telework to recruiting and retaining staff, mandates requiring return-to-office five days a week add unnecessary burden, harm the mental/physical health of employees, and detract from job performance. Additionally, targeted challenges to [reasonable accommodations](#) for HHS staff further showcase the lack of regard or respect paid to NIH workers.

## Recommendations

- **Solicit input from staff and encourage sharing of scientific ideas**—even if these ideas don't align with current agency priorities. Leadership assurance to staff that they can safely share ideas and voice concerns will help to mitigate the current climate of fear and self-censorship.
- **Promote and encourage alternative ideas, debate, and respectful dissent**, both in actions and in words.
- **Allow experts to formally document opinions, including dissenting opinions** for all actions, especially grant terminations, paused foreign collaboration, and actions that alter contents of grants in order to “align” with political review. Because there will be future liability, a clear and truthful record of how and by whom the decisions were made is essential.
- **Re-instate the annual Federal Employee Viewpoint Survey (FEVS)** and other assessments of employee satisfaction, with strong mechanisms of anonymity in place. Leadership should share results and actively commit to addressing the feedback.
- **Act instead of talk:** Director Bhattacharya repeatedly claims that he wants to inspire a culture of dissent, and yet dissent or debate is meaningless when the leadership does not listen, consider, or have the willingness to change course based on feedback from staff (including institute and center directors). We would like to see concrete actions towards restoring the culture and morale for the remaining NIH staff.

## **Closing Statement**

The [mission](#) of NIH is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. NIH must deliver on this mission through effective stewardship of taxpayer funding, which is appropriated by Congress. This report documents the ways in which NIH is grossly mismanaging taxpayer funds while failing to execute its congressionally enacted mission. Though we write this in our personal capacities, we write with the knowledge and expertise we hold through our collective experiences carrying out the NIH mission. One year ago, we were compelled to speak up. Since then, we have watched as Director Bhattacharya oversaw further damage to the infrastructure that allows NIH research to save lives. At the same time, we have seen our fellow Americans, visa-holders, naturalized citizens and domestic-born alike, rise up to support publicly funded, ethical, equitable health research. Collectively, we have decided that academic freedom and scientific excellence are non-negotiable. We will continue to support and defend the Constitution and the mission of NIH.