



AMERICAN COLLEGE OF GASTROENTEROLOGY

11333 Woodglen Drive, Suite 100, North Bethesda, Maryland, 20852-3071
P: 301-263-9000; F: 301-263-9025; Website: www.gi.org

Testimony of William D. Chey, MD, MACG, as President and on behalf of the American College of Gastroenterology

*Prepared for the Senate Subcommittee on Labor, Health and Human Services, Education,
and Related Agencies, regarding the National Institutes of Health*

Dear Chair Capito and Ranking Member Baldwin,

Thank you for the opportunity to provide testimony regarding FY 2027 funding for the National Institutes of Health (NIH). The American College of Gastroenterology represents over 20,000 GI clinicians, with a shared mission to provide world-class care to patients with digestive disorders. For 2026, I have had the honor of serving as its president, alongside my role at the University of Michigan as the H. Marvin Pollard Professor of Gastroenterology, Professor of Nutrition Sciences, and Chief, Division of Gastroenterology & Hepatology.

In its annual budget this April, the Trump administration proposed cutting NIH funding to \$41.47 billion—a decrease of \$4.8 billion compared to FY 2026.¹ We are grateful that Congress rejected a similar proposed cut last year, before passing an NIH budget with an *increase* of \$216 million in funding. We urge this committee and Congress to again reject these cuts, support NIH funding that meets or exceeds FY 2026 levels, and ensure our country retains its title as the world’s leader in biomedical research.

Scientific discovery has revolutionized our understanding of human health and disease. Consider that less than a generation ago, gastroenterologists considered peptic ulcer a chronic disease resulting from excess gastric acid production, the main therapy for patients with inflammatory bowel disease was steroids, and hepatitis C was largely incurable and one of the leading causes of cirrhosis and liver cancer. Science has led to paradigm shifts for these diseases and countless others.

For decades, the United States has been the undisputed worldwide leader in science and technology. However, we should not take it for granted that the U.S. will retain this title indefinitely. After all, until the early 1900s, our country was a relative backwater of research, with the most impactful work done in the great centers of Europe. The partnership between the federal government and academia that has produced most American medicine breakthroughs did not begin in earnest until after World War II.

¹ <https://www.hhs.gov/sites/default/files/fy-2027-budget-in-brief.pdf>

According to a 2022 report from the National Science Board, the US ranked first, spending \$923 billion on research and development, followed by China at \$813 billion.² That said, China now publishes more peer reviewed scientific manuscripts than the US and in certain key sectors—like artificial intelligence—is filing more patents than the US. Who will lead the next set of transformative biomedical breakthroughs?

As division chief of gastroenterology at the University of Michigan, I know how harmful any cuts to NIH funding would be. In fact, even without those cuts, recent changes at the NIH have already threatened the future of medical research in the United States.

First, NIH has changed its process around Notices of Funding Opportunity (NOFOs), the NIH mechanism for soliciting research ideas and awarding grants to scientists.³ Between 2012 and 2024, the agency issued about 500 to 1,000 NOFOs a year. In 2025, NIH published 120 NOFOs, more than an 80% decline from 2024. As of April 2026, the NIH has posted just 17 NOFOs.

Another change in grant funding is that many NIH institutes have adopted a “forward funding” model. This means multiyear grants are fully funded in their first year, rather than in increments over the span of three to five years. No additional money was allotted to finance this change. Because approximately 40% of awarded NIH grants were forward funded in 2025, NIH was forced to fund >5,000 fewer grants (an 8-9% drop compared to years past) and the “payline” (or minimum score necessary to make a grant fundable) decreased. For example, the National Cancer Institute (NCI) reported dropping its payline for RO1 and R21 grants from around 10% to 4%. In other words, only one of every 25 NCI R01/R21 will be funded.

This uncertainty has made it difficult to create budgets or even assign clinical effort for the faculty members who conduct basic, translational, or clinical research. It has also forced our administrative team to commit precious time and resources to planning for multiple “what if” scenarios, all but one, of course, never come to pass. In the near term, research groups and labs will be forced to fund themselves through layoffs, belt tightening, and prioritizing key themes. But a Darwinian process has already commenced, and the primary selection pressure is not ingenuity, but dollars.

Unquestionably, however, the most corrosive effect of all this uncertainty is on our investigators and, especially, young doctors considering a career in biomedical research.

A career as a physician researcher has always come with significant sacrifices—lower salary, long hours with an unwritten expectation to work nights and weekends, intense

² <https://nces.nsf.gov/pubs/nsb20257/>

³ <https://www.politico.com/newsletters/politico-pulse/2026/04/29/the-debate-over-nih-research-revamp-00896870>

competition for grant funding, and having to learn to cope with failure, sometimes accompanied by harsh criticism. As I often say to my team, only half-jokingly, “Academic medicine is a contact sport.”

However, for those bitten by the research bug, the joys of discovery, advancing science, and innovating in ways that make a difference have always been worth the sacrifices. To choose a career as a physician researcher is to understand the balance of risks and benefits, which requires the ability to quantify the risks. When young gastroenterologists are faced with the inability to estimate—let alone quantify—those risks, many talented individuals will logically opt for the more sure prospects (and steadier paycheck) of a clinical career.

Our fellowship application process this past year supports this hypothesis—typically between one third and one half of the fellow applicants we interview express a desire to pursue a career as a physician researcher. This year, of the outstanding group we interviewed, fewer than 10% wanted to pursue such a career pathway. I asked several applicants with impeccable research pedigrees why they did not want to pursue a career in research. They universally cited uncertainty and unacceptable levels of risk as key variables in their calculus. It is of course impossible to know whether this year represents an outlier or if our experience represents a ‘canary in the coalmine’ moment.

What I do know is that Congress has an opportunity to intervene before this damage becomes permanent—and this committee’s decision on FY 2027 funding will be a determining factor.

Ultimately, we must decide where biomedical research resides on our list of public priorities and whether the United States wants to continue to be *the* pre-eminent purveyor of innovative, life-changing research. And as my recent observations make clear, we must also create an environment where young doctors see a future in pursuing a career in science. We cannot afford a lost generation of physician researchers, and we cannot afford to cede our standing as the world leader in biomedical discovery to countries that are investing, not retreating. That is why I urge the committee to reject the proposed cuts, support NIH funding that meets or exceeds FY 2026 levels, and act before the question of American scientific leadership answers itself.