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The Threat to Medical Research

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FEATURES

DEEP CUTS

TONY 2.0

OMRF

Chartered in 1946, OMRF is an independent, nonprofit biomedical research institute dedicated to understanding and developing more effective treatments for human disease. Its scientists focus on such critical research areas as cancer, diseases of aging, lupus and cardiovascular disease.

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ALSO IN THIS ISSUE

Research Means Hope

Research may not have saved Sam. But it added years to his life, and life to his years.

In June, my wife and I, along with our daughter, marked the one-year anniversary of the death of our son, Sam.

Sam passed away without warning just before his 24th birthday. He lived his life with a rare neuromuscular disease. While in a technical sense the illness robbed him of his ability to speak, Sam was one of the most expressive people I've ever known. When he smiled, it lit up a room. And if he was excited, he'd let out a yelp that represented the purest expression of joy I've ever been fortunate enough to know.

In the year before his death, Sam smiled and yelped with joy often. No small number of those occasions came during OMRF's 77 for 77 tour, where he joined my wife Amy and me as we visited every county in the state to commemorate the 77th anniversary of OMRF's founding.

Those times were precious for our family. Knowing now what was to come, I feel even luckier to have shared them.

This past spring, we launched a reprise of this tour. Called Spotlight Conversations, it brought OMRF researchers to communities across the state – McAlester, Woodward, Elk City and Tahlequah – to talk about healthy aging.

In these sessions, scientists like Dr. Benjamin Miller discussed the latest research on how best to combat Father Time. Miller, an avid cyclist, trumpeted the benefits of exercise. "There's rarely a problem where I don't think, 'Oh, exercise can help that,'" says Miller. Right now, along with his colleague Dr. Sue Bodine, he's leading a watershed study exploring why working out reaps big rewards for some older people, but not others. You can read all about this study through the eyes of one participant – I won't call him a guinea pig – in "The Tony Project" (page 16).

During Spotlight Conversations, we made lots of new friends in the communities we visited. Many were people like Keith Miller (page 6), whose wife of six decades now lives with dementia. Keith gives to OMRF to support our dementia research, hoping his generosity may help others avoid the fate of his dear Linda.

These research projects – indeed, virtually every research project at OMRF and at our counterparts around the country – are made possible by the support of the National Institutes of Health. But, as you can read in our cover story, that support is now in jeopardy, with the NIH facing challenges unlike any I've witnessed in more than 30 years as a medical researcher.

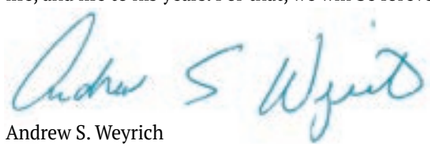
In times like these, your donations to OMRF – always vital – mean more than ever. And if you feel strongly about the work we do, please also make your voice heard. Reach out to your members of Congress to support the NIH and medical research. You can find contact information for all members of Oklahoma's congressional delegation and talking points at omrf.org/advocacy.

As the parents of a child with a disease that shaped every day he spent on this Earth, medical research always provided Amy and me with hope. Indeed, thanks in no small part to medications developed as a result of NIH-funded research, he lived decades beyond what doctors first predicted.

As we traveled the state this spring, Sam's absence would strike me at unexpected moments. But almost as quickly, I'd remember all of the Sams who are still with us, or who are yet to be born.

They – and all of us – count on scientists to continue to seek answers. For that, we need the federal government to support the NIH as it always has.

Research may not have saved Sam. But it added years to his life, and life to his years. For that, we will be forever grateful.



Andrew S. Weyrich

Cancer Therapies For Lupus?

Dear Dr. James,

Cell-based therapies have proven remarkably effective for some cancers, most notably the blood cancer multiple myeloma. I've read that these therapies may also have potential for treating autoimmune diseases like lupus. How would this work?

Adam Cohen
Ever-curious Findings editor

Dr. James Prescribes

Yes, rheumatologists like me are very excited about cell-based therapies. Some think it will be the biggest thing for autoimmune diseases since the advent of targeted biologics like Humira for rheumatoid arthritis and Benlysta for lupus.

Right now, researchers are most interested in CAR T-cell therapy, a kind of living drug. With this therapy, scientists modify patients' own immune cells and then reintroduce them to their bodies. The idea is that these modified immune cells – T cells – will fight other misbehaving cells.

Specifically, scientists engineer the T cells to wipe out disease-causing B cells. In multiple myeloma and some other cancers, B cells are the root cause of the disease. Similarly, in lupus and other autoimmune diseases, B cells play a key role, producing antibodies that attack the body's own tissues.

Although CAR T-cell therapy has yielded lifesaving results for patients with blood cancers, it has significant drawbacks. Scientists must engineer the treatment for each individual patient, which makes it extremely expensive: the one-time cost for approved cancer therapies can run $500,000 or more.

For the therapy to work, before doctors introduce the re-engineered T cells to a patient's body, the patient must undergo a course of chemotherapy. This is done to weaken the patient's existing – malfunctioning – immune system and to enable the re-engineered T cells to multiply and kill off B cells.

Right now, physician-scientists are conducting clinical trials with CAR T-cell therapy in some lupus patients to test if we can achieve results similar to those in cancer patients. While the theory behind this therapy seems to make sense, and early studies with a handful of patients have been promising, we will have to see results in many more patients to know if the theory proves true.

However, even if CAR T-cell therapy works to put lupus into remission, it comes with risks, including systemic inflammation that can cause high fevers and, on rare occasions, neurological issues. And because of the side effects that come with chemotherapy, not to mention its prohibitive cost, CAR T-cell treatment likely will not be appropriate for all lupus patients.

Most likely, its use would be limited to lupus patients with the highest risk of major organ damage. But in those patients, this revolutionary therapy could prove life-changing.

Dr. Judith James is a physician-scientist and OMRF's executive vice president and chief medical officer. Submit your health questions at omrf.org/AskDrJames.

Losing Linda

Keith Miller gives to dementia research at OMRF in hopes it will help others avoid his wife's fate

It started with a push reel lawnmower.

In 1946, at the age of 6, Keith Miller launched his grass-cutting business in the small Illinois town of Marshall. The pint-sized mogul's client list grew quickly, and he soon found himself mowing 23 lawns a week. Almost 80 years later, one of those patches of grass still stands out: that of the Mitchell family.

It was while mowing the lawn at 528 North 8th Street that he first met Linda Mitchell. She was 3 years old then.

June 12, 2025, marked Linda and Keith's 60th wedding anniversary. His wife, says Keith, now 85, "is everything good, kind and bright." He's sitting in the living room of the Norman, Oklahoma, home the couple purchased in 1975 to raise their two children. The space overflows with mementos of their life together: photos, books, the piano Linda played.

But Linda isn't there. She now lives in a memory care facility four miles away.

"I walk around the house, and everything in here" – he gestures to the art on the walls, the furnishings, the oriental rug that covers the floor – "Linda did." He chokes up, then takes a deep breath and exhales. "It's hard."

•••

In the early years, Keith and Linda's paths crossed occasionally, but it never amounted to much until a trip home during his senior year of college. A chance conversation led to a coffee date, and Keith was soon using leave during officers' training school in San Antonio to visit Linda, who was completing nursing school in Indiana.

Once married, Keith's Air Force assignment brought them to a Montana community with no available nursing positions, so Linda channeled her love for children into creating a kindergarten program for families on base. This, Keith says, was followed by "a potpourri" of public health and bedside nursing work in every community where they landed.

After Keith completed his military service and earned a master's degree at the University of Oklahoma, he began a long career in engineering and the energy business. Following a brief detour to Dallas, the couple returned to their beloved Norman for good.

Over the years, the Millers made the most of their time. That meant world travel, professional achievements, a cherished family and supporting – through service and giving – organizations whose values aligned with their own.

"We give to entities we feel will ultimately help mankind and save our planet," says Keith. Alongside many other causes – animal welfare, children, environmental conservation – they began supporting medical research at OMRF more than a decade ago.

Back then, the couple thought of the many diseases studied in OMRF's labs. But the gift would become far more personal when Linda began treatment for dementia-related symptoms in 2019 at the age of 76. By 2023, she required more care than Keith and in-home providers could offer, so she moved to a specialized facility for people living with dementia.

"You see this beautiful person who cared for others her whole life, who was so intelligent, so helpful," Keith says. "Oftentimes, she doesn't know who she is." It has been agonizing to watch the woman he loves vanish. "I've lost her once, and I'm going to lose her again."

•••

Now, Keith makes the 10-minute drive each day to help Linda eat lunch. She can no longer walk or feed herself, and she hasn't carried on a conversation for a while now. Still, Keith says, "she smiles at me. Almost every day I get at least one smile." He pulls a handkerchief from his back pocket to dab his eyes. "I think maybe she knows who I am."

Keith takes his time talking about Linda. He searches for the right words to describe a woman who shared his entire life. Until she couldn't.

"When she was still Linda, she knew what we were giving to, and she was gratified that we could help," he says. In the past two years, Keith has dug into reading about OMRF's dementia research, eventually reaching out to tour labs and meet scientists trying to make a difference for others facing the same devastating diagnosis.

Keith knows that medical research takes time. None of the studies conducted at OMRF will save his wife. But working today to benefit future generations is something he understands. And so did Linda.

"When she started at Norman Regional Hospital, she wrote training material," he says. A half-century later, during a brief hospital stay after Linda entered memory care, "the nurse helping her said it was still being used."

Keith Miller still visits his wife of 60 years each day and feeds her lunch at the memory care facility where she lives. "I think maybe she knows who I am," he says.

Uncovering the Mind's Mysteries

Alzheimer's disease, the most common form of dementia, affects more than 6 million Americans, largely women over 65. While the disease is more prevalent in women, it more often leads to early death in men. OMRF's Dr. Sarah Ocañas studies why sex differences may have an impact on brain diseases. "Our goal is to better understand the biology and the mechanisms of Alzheimer's, particularly in women, so that eventually physicians can provide a more personalized treatment approach before symptoms manifest," she says.

Dr. Sarah Ocañas

Meanwhile, OMRF's Dr. Mike Beckstead studies how overactive cells controlling dopamine, a chemical that helps with movement and signaling rewards, often precede an Alzheimer's diagnosis. This could provide the possibility for testing "long before the onset of symptoms," he says. Ultimately, he hopes the work will provide a potential target for preventing the disease altogether.

To make a gift supporting dementia research, go to give.omrf.org.

Can America's – and OMRF's – biomedical research system continue to thrive in the face of new federal funding challenges?

By Adam Cohen

CHOPPING BLOCK

When Judith James first arrived at OMRF, she'd never heard of the National Institutes of Health. Fresh off her junior year of college, the 20-year-old was getting her initial taste of laboratory work as a Sir Alexander Fleming Scholar, OMRF's summer internship program. "I had no idea how research was funded," she says.

That changed almost immediately, when a senior OMRF scientist delivered a talk to James and her fellow Fleming Scholars. He explained that the NIH was the world's largest public funder of biomedical research, that its grants enabled much of the biomedical research not only at OMRF but also at research institutes, universities and hospitals across the U.S.

James, an attentive student, took note. Less than two years later, during her first year of medical school, she wrote her first NIH grant. It requested funding through a newly developed program to support students who, like James, were pursuing both their M.D. and Ph.D. degrees.

James proposed to use the funds on a project focused on sequential epitope mapping, a method of identifying the order of amino acids on a protein that an antibody binds to. The work, she wrote, would help cast new light on the autoimmune disease lupus.

She remembers being "super excited" when the NIH funded the project. "It gave me a little bit of scientific independence because with the grant I was now able to pay my own salary" – which was $8,000 a year – "and even give myself a little raise" – to $8,800.

The project would also lay the foundation for the long and productive scientific career that has followed.

In the ensuing 34 years, James has remained continuously funded by the NIH. The grants have grown in size and scope, as has James' work. With the help of the NIH, she secured funding that enabled her to open a laboratory. And in that lab, she and her research team have focused on identifying early events in autoimmune disease.

The James lab produced the first evidence that, long before people show any clinical symptoms, telltale proteins can populate the blood of those who will go on to develop lupus. Building on that work, James led the first clinical trial aimed at preventing the disease. Her lab identified a series of biomarkers that predicted when the disease would flare. That work has now become a test that physicians across the country use to treat patients living with lupus, which can damage the joints, skin, kidneys, heart and lungs and is notoriously difficult to treat.

In essence, those federal funds did exactly what they were meant to do: They helped deepen the understanding of a devastating illness, which then led to advances that improved the lives of people living with that disease.

But everything changed earlier this year, when the new presidential administration slashed federal funding for medical research. Grant delays, cancellations and widespread layoffs at the NIH followed. For 2026, the administration has proposed a budget that would further shrink the NIH budget.

"Groundbreaking projects are now at severe risk because of budget and workforce cuts," warned Dr. Francis Collins, who led the NIH under previous administrations and during President Donald Trump's first term. In June, a group of Nobel laureates and current and former NIH scientists urged the institute's new director to reverse the cuts, cancellations, delays and layoffs. "Combined, these actions have resulted in … a dramatic reduction in life-saving research," they wrote in an open letter signed by more than 500 people.

The cuts and disruptions at the NIH have already had far-ranging impacts. They've shaken the foundations of a U.S. biomedical research enterprise that has been 80-plus years in the making and is the envy of the world. From medical schools to independent institutes, biomedical research organizations have begun trimming staff and projects.

Scientists everywhere are deeply concerned, says James, now a member of the National Academy of Medicine and

Dr. Judith James has received support for her research from the National Institutes of Health since 1991, but she's concerned about the agency's ability to continue to fund scientific projects. "No one knows what the future will look like," she says.

OMRF's executive vice president and chief medical officer. "People have invested years, if not decades, in education and specialized training. And now no one knows what the future will look like."

She finds the situation most discouraging when she thinks about young researchers who stand at a crossroads. They have to decide whether to follow the long and arduous road to a life in science – or opt for another path. "They're worried," says James. "About how their careers will unfold. About how they can do medical research that will help people living with disease and disability."

Their plight mirrors a much larger crisis in medical research, one that ultimately stands to affect each person who's ever faced a health challenge. Or has a friend or loved one who did. Or will one day.

In other words, pretty much everyone.

Today, the U.S. stands as the world's unquestioned leader in biomedical research. America dominates the global stage in biomedicine, whether measured by drug development, papers published in leading scientific journals, or Nobel Prizes. However, it wasn't always this way. As with so much in our history, World War II changed everything.

In the years leading up to the war, the federal government engaged in a massive campaign to build the country's industrial base. As part of this effort, the government began funding research at universities and research institutes. That partnership bore many fruits that helped propel the Allies to victory: not only the atomic bomb and leaps in flight and communications but also medical advances such as mass-produced penicillin, which saved many soldiers on the battlefield by treating wound infections, pneumonia and other bacterial illnesses.

Following the war, the U.S. used this blueprint to guide the expansion of the country's biomedical research infrastructure. Rather than having the NIH – first established as a single laboratory within the Marine Hospital Service in 1887 – perform the lion's share of the nation's medical research, the government expanded the agency to focus on making research grants on a competitive basis to outside entities, primarily universities, medical schools, hospitals and independent research institutes.

That formula has served America well. For example, from 2010 to 2019, the U.S. Food and Drug Administration approved 356 new drugs, including revolutionary gene therapies for previously incurable diseases and immunotherapies that have transformed the treatment landscape for cancer. Of these new medications, 99.4% (all but 2 of the 356) stemmed from research funded by the NIH.

These advances have saved countless lives. As a result, the agency has consistently enjoyed bipartisan support.

Lives Changed. Lives Saved.

Economists found that of the new drugs approved by the U.S. Food and Drug Administration between 2010 and 2019, more than 99% had their roots in projects funded by the National Institutes of Health.

That study rings true at OMRF, where NIH grants have planted the seeds for three life-changing drugs:

- **Adakveo** a therapy for the pain crises in sickle cell disease
- **Ceprotin** used most often to treat children suffering from a life-threatening blood disorder
- **Soliris** a treatment for several rare autoimmune conditions

NIH funding also laid the groundwork for a pair of OMRF-based disease management tests now available in hospitals and clinics everywhere:

- **Vectra DA** for rheumatoid arthritis
- **aiSLE DX** for lupus

- **OKN-007** for brain cancer

On the horizon is OKN-007, an investigational new drug undergoing clinical trials for glioblastoma, a deadly form of brain cancer. The drug, which likewise has its roots in NIH-funded research at OMRF, has received fast-track designation from the FDA to treat an especially aggressive form of glioblastoma known as DIPG, which primarily strikes children and is almost always fatal.

In addition to improving the nation's health, investments in the NIH have also paid significant economic dividends. Every dollar spent on scientific research and development returns about $5 in economic gains. And this figure probably underestimates the true return, as it fails to capture benefits that aren't reflected in measures of gross domestic product, like longer lives and more time and ability to participate in activities that feed the economy.

"It's like a machine – you put a dollar in the machine and you get $5 back," a Northwestern University economist recently told The New York Times. "From a societal point of view, it's an incredibly high-return activity."

That machine was chugging along just as it had for decades until the new administration took office in January 2025. In rapid succession, the NIH announced a hiring freeze, a communications pause and cancellations of routine grant-review meetings. Federal officials then issued sweeping executive orders terminating federal support for a wide range of initiatives, which sent NIH personnel scrambling to identify and cancel non-compliant grants and programs. An across-the-board pause on all federal grantmaking activities came next, followed by what The Washington Post described as "the biggest blow yet": a drastic reduction in the formula by which the NIH reimburses 2,500 outside institutions for the costs of performing research.

The measures were met by a blizzard of lawsuits and subsequent court orders, many of which would eventually pause or halt implementation of the new policies. In the meantime, NIH staffers struggled to make sense of the confusing and rapidly changing legal landscape they suddenly found themselves in.

"By and large in my experience, the federal workforce is very conscientious," says Dr. Carrie Wolinetz, a former senior NIH official who now helps lead the Washington office of the Association of Independent Research Institutes, of which OMRF is a member. "They recognize they are subject to the policies of the administration, and they want to make sure they are on the right side of the law."

Uncertainty at the agency further snowballed when the NIH began laying off staff. The firings began with junior employees, but the reductions quickly spread to personnel at all levels of seniority, and across all functions at the 27 institutes and centers that make up the agency. Longtime scientific leaders within the NIH were swept up in the departures; some terminated, others leaving abruptly with little or no explanation.

"There's been a mass exodus, and many of the people who are gone are the ones who've been at the NIH for many years and have responsibilities for large programs," says Dr. Andy Weyrich, OMRF's president. "And the people who were still in their early years, many of them are gone too."

Together, these developments have staggered the NIH and left those who rely on the agency reeling. Thousands of grants have been canceled or delayed. Meanwhile, the review process for new grant applications froze for a time. And when it resumed, it did so only at a crawl.

With communications blackouts and firings, scientists who depend on NIH support to fund their research struggled to get answers about when – or even if – new or delayed funds would be released. Often, says Weyrich, researchers' queries have been greeted only with silence. "We don't know if someone's not responding because they've been instructed not to, because they have no information to share, or because they're simply gone."

In the first half of 2025, federal funding for medical research dropped almost 30%.

According to an analysis by STAT News, the awarding of new NIH grants through mid-June 2025 plummeted by $4.7 billion compared with the average over the nine previous years, a decline of 29%. At OMRF, the drop has been even steeper.

OMRF supports its operations through a variety of income sources; the largest of these is NIH grants. For fiscal year 2024, those grant revenues totaled slightly more than $49 million, which represents almost 40% of OMRF's annual operating budget.

In the first five months of calendar year 2024, OMRF had $20.5 million in NIH revenues. For that timeframe in 2025, that figure slid by nearly half, to $11.3 million. Through the same period, OMRF scientists have received only two new NIH grants in 2025, versus eight the previous year.

Over time, if the administration's new policies remain in place, OMRF projects an annual loss of $18 million in revenues. And that shortfall fails to fully take into account the administration's proposed going-forward federal budget. That draft budget, released late in the spring of 2025 and, at press time, still under negotiation with the House and Senate, requests further paring of the NIH, from current yearly funding levels of $47 billion to $27 billion.

Weyrich has been a medical researcher for more than three decades. In that time, he's lived through several previous reductions to the NIH budget. In each of those earlier instances, the cuts weren't nearly as substantial, and legislators quickly compensated by replenishing the NIH budget in subsequent years.

"But this time feels different," he says. The depth and breadth of the cuts, coupled with the grant cancellations and downsizing of the NIH workforce, pose "an existential threat" to a system the country has worked long and hard to build. "And research is not like a light switch. It's not something that can be turned off and then just flipped back on."

At OMRF, the adjustments have already begun. The foundation enacted an across-the-board cut in non-personnel expenses, plus hiring and salary freezes. Administrators placed an indefinite hold on a long-planned buildout of laboratories for the Arthritis & Clinical Immunology Research Program. And in May, OMRF rolled out a voluntary retirement plan for long-serving, senior employees.

The measures mirror similar ones at institutions across the country: Michigan State University, Duke University, Columbia University, Rice University and many others have taken steps to reduce their workforces and trim other expenses. The hope is that these cost-saving measures can be revisited if the situation at NIH brightens. If it does not, says Weyrich, these actions may only be the prelude to more drastic cuts.

"The system we've established in partnership with the government is just that – a partnership," he says. "If the government continues to slash research support, the entire system will have to be downsized accordingly. We won't have a choice."

Following litigation, the NIH reinstated a grant to Dr. Jordan Fuqua that will enable him to open his own laboratory to study muscle loss in aging. But other OMRF researchers who've faced grant cancellations or delays at the agency haven't been so fortunate.

Dr. Jordan Fuqua knows the impact of those cuts firsthand.

A native Oklahoman, Fuqua loved sports as a kid. At Wewoka High, he ran track and played basketball and football, and that childhood passion helped fuel his decision to pursue a career in exercise physiology. After earning undergraduate and master's degrees at Brigham Young University in Utah, he went on to pursue a Ph.D. at the University of Iowa.

In Iowa, he spent a considerable amount of time in the laboratory, studying muscles. In particular, he developed an expertise investigating a process known as sarcopenia, the loss of muscle as we age. As he delved deeper, he realized that he'd like to run his own research lab, where he'd aim to develop ways to counter this process. But to do so, he'd need additional training.

After completing his Ph.D., Fuqua came to OMRF for that postdoctoral training. He joined the lab of Dr. Benjamin Miller, where he performed research on skeletal muscles, which connect to our bones and allow us to perform a wide range of functions. With Miller's guidance, he worked hard on his grant writing skills. He spent about two years preparing a pair of NIH applications that ultimately fell short of the funding line, the cut-off for successful submissions.

Fuqua redoubled his efforts, devoting another half-year-plus to gathering additional data and otherwise responding to comments previous grant reviewers had made. The final three months leading up to the deadline, he says, "were probably the hardest of my life."

When it came time to submit, Fuqua chose to apply through the NIH's MOSAIC – Maximizing Opportunities for Scientific and Academic Independent Careers – program. The five-year grant would provide a springboard for him to transition from his postdoctoral fellowship to opening his own lab. The MOSAIC program was one of two avenues to receive this type of grant, each of which was "extremely competitive" and offered similar funding chances, says Fuqua, in the 15%-20% range. He chose MOSAIC because, in addition to monetary support for his research, which both mechanisms provided, it "offered more mentoring and training, which I thought would be very helpful to furthering my career."

The MOSAIC program also fell under a broad umbrella of diversity initiatives at the NIH. To qualify, applicants had to meet at least two (out of a possible seven) requirements to demonstrate they'd come from a background that was different from the majority of researchers who receive funding from the agency.

Fuqua checked three of those boxes. First, he'd grown up in a rural area. Second, as someone who'd qualified for free lunches throughout his upbringing, he'd come from a socioeconomically disadvantaged background. Finally, he's an enrolled member of the Citizen Potawatomi Nation, a federally recognized tribe headquartered in Shawnee.

Six months later, Fuqua learned his application would be funded. It was an "amazing" feeling, he says. "This grant would be career-changing. Life-changing." He'd receive $1 million over five years: $250,000 to complete his postdoctoral work, then the rest to open his own lab, the final step in his journey to scientific independence.

It had already been quite an odyssey. With his undergraduate, master's and doctoral education, plus his

postdoctoral training, Fuqua, 37, had spent more than a decade and a half to reach this moment.

He and his wife, Kaylee, had made considerable sacrifices along the way. Together, they'd hopscotched across the middle of the country while raising a growing family – they now have five children, aged from just under a year to 10 – on a single, modest income. "We did this because we believe in the power of science," Kaylee says, "so that Jordan could fully pursue meaningful, life-changing research."

That journey, though, took an unwelcome detour when Fuqua received notification from the NIH in late May that his grant had been terminated, part of a larger rollback of the entire MOSAIC program. "With that grant, I felt like I had a lot of momentum," he says. "Whenever I was ready to start applying for jobs, I would have had funds to bring with me to pay my salary and support research projects. And now I don't have that."

"It totally puts you back to nothing."

Many others who'd received and then lost their MOSAIC grants, along with junior scientists everywhere, are now contemplating alternative career paths, he says. But not Fuqua. "It doesn't change anything for me. I was committed. I'm still committed."

The MOSAIC grant would have set him up for success. Without the funding, Fuqua still believed he could find a way forward to conduct research on aging that will help people stay healthier and stronger for longer. "It's just going to be more challenging now," he told Findings in June.

In July, just before this issue went to print, Fuqua received notice that the NIH had restored his grant. The reversal came on the heels of a lawsuit that had restored nearly 1,000 grants that, like Fuqua's, the administration had rescinded.

When Fuqua got the news, he was understandably elated. "This," he says, "is an answer to my prayers."

While the NIH reinstated Fuqua's funding, many of his OMRF colleagues haven't been so fortunate. The NIH terminated a grant that funded all of the research of one of OMRF's senior immunologists. A new position for an OMRF postdoctoral researcher at the Oklahoma City VA Medical Center disappeared when the Department of Governmental Efficiency axed probationary employees across nearly every branch of government. Swept up in the cuts, too, was funding for a summer internship program for Langston University students OMRF had run in partnership with the VA. A scientist in OMRF's Aging & Metabolism Research Program likewise lost a longstanding project with the National Aeronautics and Space Administration.

Dozens of other OMRF researchers continue to fight to run their labs as funding for existing grants and review of new proposals remains in a state of suspended animation. Like their counterparts across the country, OMRF scientists are struggling to figure out when – or even if – decisions and funding may arrive, while simultaneously making contingency plans and searching for other sources of funding. All of it, says Dr. Courtney Griffin, OMRF's vice president of research, "is a really inefficient use of time." That time, she says, "would be much better spent on biomedical research."

Griffin should know. She has spent more than six months awaiting the final year of funding on a grant she secured in 2019. The grant was for seven years, and the NIH doles out the money one year at a time, with each subsequent annual award – called a "non-competing renewal" – arriving almost automatically. Until now.

After months of anxious waiting and halting communications with the NIH program officer assigned to her grant, Griffin learned that her funds were tied up because her research project used a specialized type of mouse she'd obtained from a scientist in Great Britain. Because the administration views any foreign collaboration with deep suspicion, Griffin's grant had been relegated to a special purgatory, awaiting review by unidentified individuals within the NIH.

"Supporting scientific research is one of the wisest long-term investments we can make in our country."

In the meantime, Griffin's available funding is running dangerously low. She worries about how she'll maintain her lab, where she's made a series of breakthroughs in recent years that could lead to new ways to prevent blindness in infants born prematurely and to treat diabetic retinopathy.

"There's not a night I don't lose sleep over this," she says. "I shudder to think how often this same story is playing out across the country and how much ground we're losing every single day."

Dr. Rod McEver couldn't agree more. Now retired, McEver preceded Griffin as vice president of research at the foundation, where he also ran a laboratory for more than three decades.

When McEver arrived at OMRF in 1987, he came with a pair of NIH grants he'd secured. Those funds, he says, were "critical" to getting his lab started. They allowed him to hire research staff, help pay his own salary, and buy supplies and scientific reagents to perform experiments. Within two years, he'd made a major breakthrough, discovering a new family of proteins in the blood.

Over the ensuing decades, with steady NIH support, he and his colleagues developed an understanding of how those proteins, called selectins, functioned. Among other things, they found that selectins play a crucial role in wound healing; the scientists also linked the proteins to various illnesses.

With a scientific collaborator, McEver launched a start-up company focused on the role that selectins play in sickle cell disease, a debilitating blood disorder that can lead to organ failure and even death. The company developed an experimental drug and, with the help of NIH small-business grants, conducted early-stage clinical trials.

Following the success of those and another round of trials, the drug, acquired by the pharmaceutical company Novartis and now called Adakveo, received approval from the FDA. It became the first therapy approved in a quarter century for the pain crises in sickle cell disease, and doctors now use it to treat patients in the U.S. and around the world.

None of this, says McEver, would have been possible without consistent support from the NIH. And he worries that in today's dire funding environment, the story might have a very different ending.

"With the kinds of draconian cuts at the NIH, there's a major question about whether my initial grant applications would have been successful," he says. "I might have decided there wasn't a path forward for me in academic medicine. I might have given up."

People often assume that pharmaceutical companies could duplicate this process without scientists at universities, medical schools and nonprofit research institutes like OMRF. But, says McEver, there's a reason that well over 90% of therapies available to patients today had their seeds in publicly funded research like his. "The drug companies depend on this pipeline for discoveries and new ideas."

Dr. Rod McEver's research created a drug to treat sickle cell disease. Without support from the NIH, he says, "I might have given up."

Today, he says, America's biomedical research system teeters "on the precipice." If the funding cuts stand, "There's going to be a tremendous loss of infrastructure." That loss, he says, could take a generation to reverse. "If it goes on even for a few years, it will drive countless people out of the field, and it will discourage young people from entering the field. Institutions will contract."

McEver hopes never to see a tomorrow where the nation's medical research infrastructure gets hollowed out. "You'd lose a loved one who in an alternative world might have been saved." Cancer therapies that are never discovered. Treatments for Alzheimer's that fail to materialize. "You just don't know."

But, he says, that doesn't have to be our future.

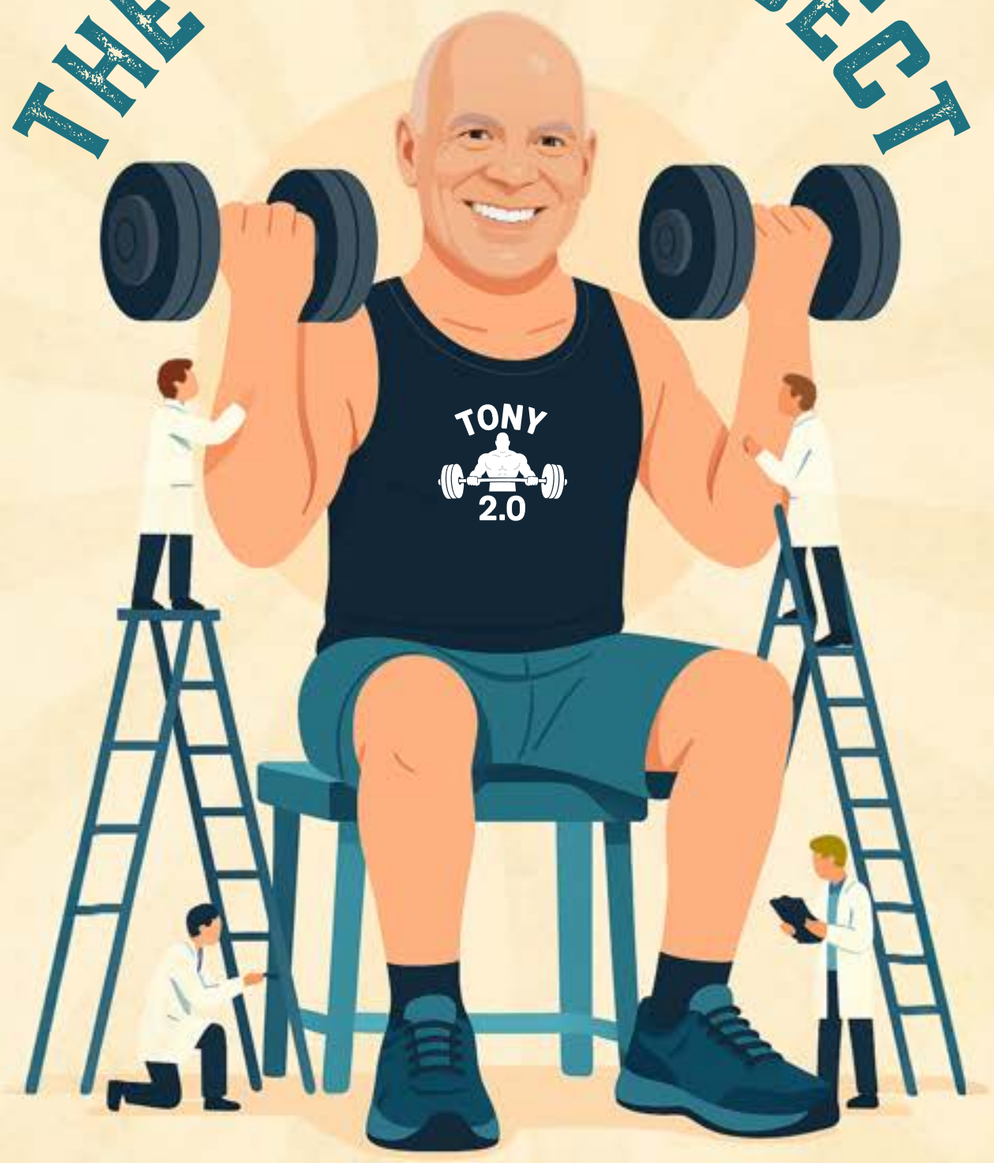
"It simply takes citizens of whatever party to realize that this needs to be faced resolutely, that supporting scientific research is one of the wisest long-term investments we can make in our country." He ticks off some of the many benefits to our nation: healthier citizens, economic returns, intellectual vitality, national security.

Plus, he says, there's something almost transcendent about the process of scientific discovery. "Revealing the secrets of the world in which we live is ennobling to the human spirit." In no small part, "It helps make us human." ◙

You Can Help

If medical research is important to you, it's not too late to make a difference! Call or write to your members of Congress and let them know that it's important to fund the National Institutes of Health at current levels and that cutting support for the NIH and its granting activities imperils the nation's health and economy. You can find contact information for all members of Oklahoma's congressional delegation and talking points at omrf.org/advocacy.

THE TONY PROJECT



I KNEW I NEEDED TO TAKE BETTER CARE OF MYSELF. AN OMRF EXERCISE STUDY OFFERED ME THE CHANCE TO DO JUST THAT.

BY TONY THORNTON

I am 63 years old. My wife, Jenn, is a decade younger.

Given our age difference, we both know the odds are high that someday Jenn will have a dual role as wife and caretaker. Our aim has always been to delay that as long as possible. Still, in our time together, I'd taken virtually no steps toward that goal.

Then, this past winter, I saw a perfect opportunity to change that. I work at OMRF as a staff writer and media relations manager. A pair of my coworkers, OMRF scientists Drs. Benjamin Miller and Sue Bodine, had received a grant from the National Institute on Aging. With those funds, they'd lead a major exercise study at OMRF, one that seeks to understand why some older people benefit from exercise more than others. To solve this mystery, they needed people like me: those over 60 who currently work out little, if at all.

The study would involve two phases. In the first, participants would undergo 12 weeks of supervised strength and endurance training. Then, following testing, participants would either continue workouts with a trainer for another 10 weeks or be released from supervised exercise.

Yes, participating would be a big commitment. But it would give me a chance to do what I'd long intended: to get serious about exercise and my health.

While I average 10,000 steps a day, regular cardio and strength training were not part of my routine. The closest I came to working out was walking the dog and doing yardwork.

Also, if I'm being honest, I'm probably carrying about 20 more pounds around my mid-section than I should. I take a daily blood-pressure pill and live with the fear of crossing the line from pre-diabetes to full-blown Type 2.

One morning over coffee, I mentioned Miller and Bodine's new exercise study to Jenn. I told her about the type of person they were seeking to participate.

"That sounds just like you," she said. "You should do this."

In mid-February, I initialed each of the 15 pages of the study's consent form. Still, simply deciding to volunteer wouldn't suffice. Study staff would administer a battery of tests to ensure I met the project's specific criteria, minimizing the chances I had any hidden health conditions that might jeopardize me or the study.

Weeks later, a clinical research coordinator took several vials of my blood and applied electrocardiogram (ECG) nodes to my chest for a heart assessment. I received a passing grade on those, and my medical history questionnaire also got a thumbs-up. That left only a final hurdle to qualify: an assessment known as a VO2 max test.

VO2 max measures the maximum amount of oxygen your body can use during exercise. It's a key indicator of a person's aerobic fitness. Essentially, the higher the number, the better. To participate in the study, I needed to hit a figure that would demonstrate my body was capable of handling the regimen trainers had mapped out for participants.

For the test, study staff again attached ECG nodes to my chest, which would measure my heart rate and rhythm and detect any potential abnormalities that might signal a danger like an arrhythmia or blockage. They also fitted me with an oxygen mask, which would track how much oxygen I inhaled and how much carbon dioxide I exhaled.

Under the watchful eye of three members of the study team, I pedaled on a specially designed stationary bike. The device steadily cranked up the resistance, simulating the feeling of climbing an ever-steepening hill. At the 11-minute mark, my lungs burning, I waved the white flag.

I had scored 31.5, meaning that during exercise, my body consumed that many milliliters of oxygen per kilogram of my body weight. It also indicated I was moderately fit for a man my age. And, most importantly, it meant I had qualified to participate in the study.

Before I could officially begin, I spent three weeks in a "ramp-up" period designed to determine my exercise baseline to accurately chart my progress. As part of this, study staff fitted me with an Oura Ring, which tracks metrics like sleep, activity, heart rate and body temperature.

"Devices like the Oura Ring are typically intended to provide biofeedback for the people who wear them," says Miller, an exercise physiologist who joined OMRF from

I'D DO THE WORKOUTS FIRST THING IN THE MORNING, AND THEY COULD BE GRUELING.

Colorado State University in 2018 and now leads the foundation's Aging & Metabolism Research Program. "The idea is that people will see that information and then modify their behavior by doing things like getting more sleep or eating a healthier diet."

But for the study, only the researchers would view that information. I would be blind to what was happening inside my body.

"Other than the exercise program, we do not want participants to alter anything they are currently doing," says Miller. "That way, we will know that any physiological changes that take place – or do not – are attributable to exercise alone."

Miller and his team assigned Dr. Gustavo Oliveira de Sousa as my personal trainer. He would guide me through the ramp-up and 12-week first phase of the exercise study.

Measuring the Years

Certain tests help predict how long a person might enjoy a healthy life. In addition to the usual suspects like body mass index, cholesterol and blood pressure, here are four key indicators researchers leading OMRF's exercise study are tracking in participants age 60 and over.

VO2 max: This test measures the maximum volume of oxygen used during exercise; a low score signals increased risk of cardiovascular disease and mortality.

Knee extension strength: Knee strength improves balance and can prevent falls. To gauge it, researchers use the maximum weight a person can lift for one complete repetition of a knee extension.

Six-minute walk: The farther someone can walk on a flat, hard surface in six minutes, the better their aerobic capacity and endurance.

Glucose: High blood sugar levels flag a person's risk of developing Type 2 diabetes.

I knew Sousa as an ever-smiling staff scientist in Bodine's lab, which is located a few hundred steps from my desk. What I'd soon find out is that he's also a competitive weightlifter and jiujitsu practitioner who'd helped train Brazil's national judo team and interned with the strength and conditioning staff of the University of Iowa's football team.

As you might guess from this background, he takes exercise pretty seriously.

I got my initial taste of this on the Monday morning I showed up for my first session. When Sousa handed me a sheet with the day's workout, I gulped. After a long warm-up on the stationary bike, I'd rotate through 12 different weight-lifting stations, doing three sets of 12 repetitions each.

The weight levels he assigned me seemed reasonable, and I fared okay for a bit. But as the session wore on, my muscles began to fatigue, often before I reached the end of my sets. At some point, as I struggled to complete one more rep, I let out a roar.

Sousa smiled. It was a different kind of smile – or maybe I was just seeing it differently? – than the one I'd grown accustomed to in the halls of OMRF. This one seemed to say, "Enjoy your suffering."

As the weeks went by, my exercise routine began to take on a rhythm. Mondays and Fridays were longer sessions, lasting 90 minutes or so. They blended cardio and strength: a half-hour on the stationary bike, followed by an hour of resistance training, where I'd work through multiple circuits of upper body, core and leg work.

Wednesdays offered a bit of a respite. Well, sort of. The sessions were shorter, taking only an hour. But during the cardio portion, Sousa amped up the intensity.

Instead of Monday's and Friday's sessions on the bike at even pace, he chopped the time up into a series of on-and-off intervals. For one minute, I'd go pretty much all out, with the goal to get my heart rate up to a whopping 160. (At first, I was concerned when I saw my pulse spike to this number, but study staff assured me it wasn't a danger signal.) The next minute, I'd pedal easy, aiming to let my heart rate drop back down to 140 or so. We'd keep repeating this sequence until, mercifully, the timer on Sousa's phone would signal that my aerobic suffering was at an end. Then, it was time to move to the weights.

I'd do the workouts first thing in the morning, and they could be grueling. Even after cooling down, showering and getting dressed, I regularly arrived at my desk red-faced. One morning, as I sat trying to pound out a press release, I felt dizzy and nauseated.

Luckily, I quickly realized I was dehydrated. A couple of liters of water and the passage of time helped me feel better. From that day forward, I made it a point always to hydrate during my workouts.

Miller and Bodine developed the workouts in conjunction with another collaborator on the study. The regimen, says Miller, finds its roots in a pair of sources: recommendations

During the study, Tony Thornton worked out three mornings a week under the watchful eye of Dr. Gustavo Oliveira de Sousa.

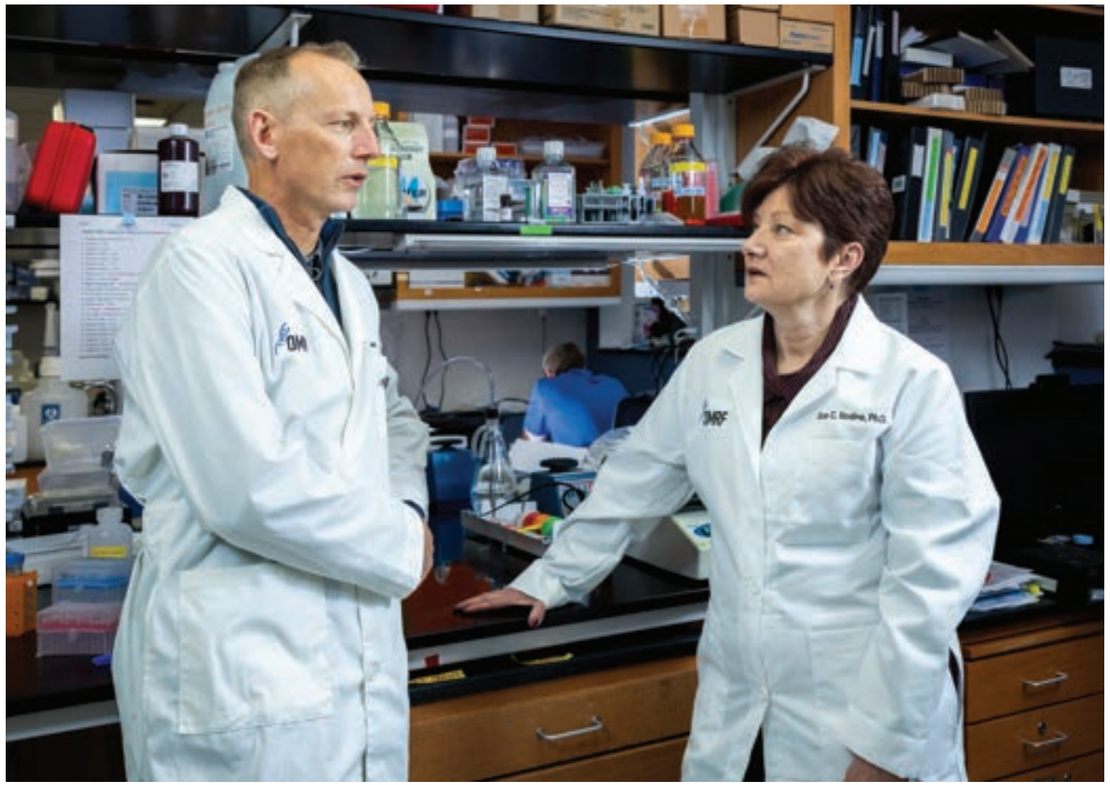
Interested in Joining OMRF's Exercise Study?

Age: 60 and above

Commitment: 28 weeks

Exclusions: Chronic health conditions like diabetes and heart disease

Find out more:
Visit omrf.org/ExerciseStudy or call 405-271-7745



For Drs. Benjamin Miller and Sue Bodine, this exercise study offers a chance to understand why some older people respond to exercise – and to figure out ways to help those who don't.

for strength and endurance training from the U.S. Centers for Disease Control and Prevention, and exercise protocols utilized in another study.

Bodine helps lead that other study, known as Molecular Transducers of Physical Activity Consortium, or MoTrPAC. A decade-long project, it involves 700 experts from OMRF and 28 other institutions collaborating on a range of experiments – both in the gym and the laboratory – to determine more precisely how physical activity improves health and prevents chronic disease.

"MoTrPAC is looking at exercise in people of all ages," says Bodine. "With this new study, we want to zero in on how the effects of exercise can vary from person to person as we grow older – and then how we can help each individual optimize these effects."

This focus aligns with a larger theme of the dozen-plus labs at OMRF that study aging, says Miller. "Our goal is not to increase people's lifespans to 150 years. Instead, we aim to lengthen the healthspan, that period of time people live free of disability and disease."

Central to that quest, he says, is preventing age-related muscle loss. "Muscle is essential to maintaining independence and a healthy metabolism."

It all makes perfect sense to me. I just hope I'm not too late.

My workouts take place in OMRF's employee fitness center, which the foundation opened in 2011. All staff can use the center at no charge. But in my four years at OMRF, until I signed up for this study, I never had.

As I was working out one day, a manager of one of OMRF's 60 or so scientific laboratories stopped me between sets. We'd seen each other many times during my years at the foundation, but we'd never formally met.

"You've been in here, week after week, working hard," he said. "I can really see you're making progress."

I grinned. "Thank you."

He, a gym regular with bulging muscles, smiled back. "Keep up the good work."

That message of encouragement echoed long after our conversation, providing a spark that fueled me throughout the rest of the session. And his words would prove the first of many coworkers' compliments, each reminding me of the outsized power of kindness and support.

In April, a reporter from the local ABC TV affiliate interviewed a member of Miller's lab about the exercise study. In the background – what people in my line of work call "B roll" – I performed a variety of strength training exercises.

The resulting story prompted more than 200 inquiries from viewers interested in joining the study.

I, of course, understood that viewers' desires to join were likely spurred by motivations like my own. Still, I couldn't help but feel proud. Maybe, just maybe, that footage of me pumping iron helped inspire them to reach out. If I could do it, so could they.

In June, Jenn and I went on a long-scheduled bucket-list trip to South America. The itinerary, mapped out by the company organizing the tour, consisted of several hikes and bike rides at altitudes above 10,000 feet.

Even a few months earlier, there's no way I could've completed these activities. But on the strength of my new training regimen, I not only finished the hikes and rides, but I enjoyed them. When we got home, I requested a new bike as my Father's Day gift. (Jenn and the kids happily complied.)

I've now wrapped up the first phase of the study and, as of this writing, am awaiting the results of testing to find out what phase 2 will look like: more supervised exercise or what study staff calls "free living."

When I first signed up, I was fixated on making enough progress to be released from my thrice-weekly sessions with Sousa. It would, I told myself, be my get-out-of-jail card, a chance to return to a more relaxed – meaning sedentary – life. But in the months since, a funny thing has happened. In fact, many things have happened.

I've grown stronger. I know this not only from improvements in the strength training portions of my workouts but simply from looking at my body. And, most importantly to me, Jenn notices.

Since I began the study, my stamina has also improved. As has my mood. Coworkers tell me there's a skip to my step that wasn't there when the year began.

These days, I feel more mentally sharp, too. Decisions seem to come easier and more quickly. I didn't expect such a benefit, but Bodine says it's a natural physiological response; previous research has shown a clear connection between exercise and cognitive improvement in older adults.

Another person who's taken note of the "new" Tony is my stepdad, Niles Jackson. Seeing what my new routine has done for me, he decided to sign up for the study.

Miller and Bodine's team worried that, at age 83 and with a knee replacement, Niles wouldn't be able to handle the VO2 test. But he did just fine, and he now counts himself as the OMRF study's oldest participant.

Design Your Own Anti-Aging Program

Deep down, most of us who don't exercise regularly know we should. The evidence is clear.

According to the U.S. Centers for Disease Control and Prevention, people over age 65 who become active soon see improved sleep quality and reductions in anxiety and blood pressure. Consistent exercise brings benefits ranging from weight maintenance to improved bone density to reductions in the risk of falls and cancer.

"Ultimately, we know that people who stay active enjoy a longer period of independent living," says Dr. Matt Bubak, a scientist who's working on OMRF's exercise study.

The options for getting and staying active are almost limitless. You can work out alone, with a partner or as part of a group, all with or without a trainer. Any combination of yoga, Pilates, aerobic exercise and strength training can yield quick health gains, Bubak says. Even short walks or bike rides around your neighborhood boost your physical and mental health. And, he says, "It's never too late to start."

"I've always considered myself an adventurous person, but laziness led to deterioration, which led to more laziness," Niles told me recently. "This gives me an opportunity to change that."

By the time you read this, I'll either be continuing my exercise regimen under Sousa's watchful eye or left to my own devices. Regardless, I've resolved to keep working out.

We're forever searching for a way to turn back the clock. In exercise, I feel like I've found it. It's not easy, and I know it won't keep time at bay forever. But given the alternative, I plan to keep hitting the gym as long as I can.

Superfan

For one OMRF immunologist there's no curing Thunder Mania

When the Thunder first arrived in Oklahoma City in 2008, it barely registered on Dr. Linda Thompson's radar. An immunologist who'd devoted much of her career to studying children born without a functioning immune system – "That was my passion," she says – she'd never had much of an interest in professional basketball.

Sure, as an undergraduate and graduate student at the University of Michigan in the 1960s and '70s, she'd attended every men's home game for eight straight years. But that was college basketball. "And the team was no good," she says.

In the ensuing decades, Thompson, who holds the Putnam City Schools Distinguished Chair in Cancer Research at OMRF, developed an antibody to a protein that plays a role in the growth of certain tumors. Versions of that antibody are now undergoing clinical trials to treat several different cancers.

She also led a five-year project at OMRF to study influenza and why certain people fail to develop immune responses to vaccination. And in the latter chapters of her career, she secured a mentoring grant that has helped numerous young researchers launch their independent scientific careers.

In other words, she had a pretty good excuse for taking her eye off the ball.

But by 2011, she says, she found it harder and harder to ignore Oklahoma City's first major pro sports team. "I'd hear on the radio that the Thunder won. Then the next day, I'd hear they won again." She thought, "Hmm, these guys" – at that time, the team was led by future NBA most valuable players Kevin Durant, Russell Westbrook and James Harden – "must be halfway decent." After landing tickets to a couple of playoff games, she was hooked. The next year, she and her longtime partner, Dr. Tim Mather, bought season tickets.

In the 14 seasons since, Thompson and Mather have been fixtures at Paycom Center. "I've never missed a game when I was in town," she says. "And I never schedule a vacation where I'd miss one." With playoff games, she estimates they've attended close to 600 games in total.

Unnamed OMRF sources report that in at least a half dozen of those contests, she and Mather have been featured on the Love's Kiss Cam.

•••

Their tickets started in Loud City, the upper level of the arena, where play on the court can resemble the view from an airplane. Eventually, a colleague at the University of Oklahoma Health Sciences Center offered a chance to share tickets closer to the court. Still, this arrangement meant the couple would only get to attend half the games, which Thompson deemed insufficient. She and Mather decided to accept the offer – but also keep their existing tickets, which they'd continue to use for "off" games.

The setup proved to have an unexpected upside. When sitting closer to the floor, Thompson would give her Loud City seats to fellow OMRFers, often junior scientists whose careers she helped guide as part of her day job. Dr. Jake Kirkland was one of the frequent beneficiaries of Thompson's generosity.

A Northern California native who grew up a diehard Golden State Warriors fan, Kirkland remembers his interview with Thompson when he was first seeking a job at OMRF. "We talked science for a quarter of it and basketball the rest," he says. When he took the position at OMRF, the Thunder were in the midst of a rebuild, mired near the bottom of the Western Conference standings. "They were terrible," remembers Kirkland. "But Linda would give me her extra tickets to entice me to become a Thunder fan." It worked. Kirkland now has his own season tickets and says the Thunder rank "a very close second" in his heart, trailing only his beloved Warriors.

In addition to sharing her hoops tickets and insights ("There's no one better to talk basketball with than Linda," says Kirkland), Thompson has served as "an incredible mentor" to the young cell biologist. "She read the first five grants I wrote, line by line," he says. "She's so giving of her time, and she's really helped me improve as a writer."

Thompson's teaching style calls to mind that of an NBA legend, says Kirkland. "She's like Gregg Popovich" – the recently retired San Antonio Spurs coach who led his teams to five NBA championships. "She's very honest, sometimes brutally so. But that kind of honesty and tough love are what you need to get better."

Dr. Linda Thompson estimates she has attended nearly 600 Thunder games. "I never get tired of it," she says.

•••

Thompson religiously listens to podcasts about the Thunder and the NBA, even in the offseason. "I am fascinated by people who strive for excellence," she says. "These guys are working harder at being athletes than we are at being scientists."

She watches every road game on television, and she and Mather even traveled to a few this past season. Decked out in Thunder regalia, she particularly enjoyed a game in Manhattan against the New York Knicks. "We killed them," she says.

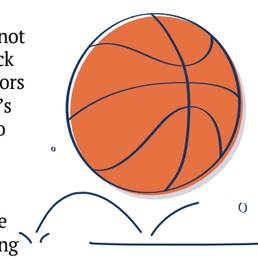
Although she's usually a yeller, whether at Paycom or home on her sofa, she says she behaved herself in Madison Square Garden. "I don't want to make a fuss in somebody else's arena."

Thompson's game attendance never wavered during the Thunder's lean years, although she didn't like the empty seats around her. "I thought that part of being a season ticket holder was supporting the team. When they're down, you don't abandon them," she says. "You don't leave."

She'd always hoped the Thunder would win a championship while she – now 77 – was still able to attend games. And midway through the 2024-25 season, she realized this might be the year. By the time the team reached the NBA Finals against the Indiana Pacers in June, she says she was "a wreck. It was so stressful."

She didn't care for herself, she says. Her concern was for the players. She'd never met any of them, but she'd watched them play for years and seen countless interviews. "They're so reflective, and you get an idea of who they are as people," she says.

When the Thunder won the deciding seventh game of the series, "It was kind of unreal," Thompson says. In no small part, she chalks the crown up to Oklahoma City's home-court advantage, to the energy and noise she and 18,000-plus others brought each night. "How can an opposing team come in here and feel like they have a chance to win? It's so amazing."



An NBA team has not captured back-to-back titles since the Warriors in 2017 and 2018. "It's almost impossible, so I don't think people should expect that," Thompson says.

But win or lose, she plans to keep spending every game night at Paycom as long as she can. "I never get tired of it. I never don't want to go," she says. "It's my home away from home."

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Class of 2025

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Teen Advocates

OMRF welcomes the 2026 class of Teen Leaders this fall. The 13th class will add to the more than 400 students who've already graduated from the program, which teaches high schoolers to support philanthropy and build their community. The program has its roots in OMRF's early days with the Lamplighters, teen volunteers who, beginning in 1954, canvassed Oklahoma City neighborhoods for donations.