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Encroachment on the Medical Profession

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In this Feature, we document the recent erosion of the medical profession's ability to self-regulate, a trend which we define, in part, as substituting political and legal judgments for evidence-based medical decision-making. Historically, medicine developed a system of professional autonomy grounded in standardized education, certification, peer oversight, scientific inquiry, and shared decision-making between physicians and patients. Although government has long regulated healthcare to protect public health and safety, recent regulatory, judicial, and legislative actions increasingly reach beyond those functions in ways that can undermine medical decision-making and the ability to provide evidence-based standard of care medical services.

In our exploration of this "encroachment," we analyze recent examples involving abortion, gender-affirming care, Medicaid provider choice, preventive-care recommendations, vaccine policy, and federal-funding conditions. Particular attention is given to Medina v. Planned Parenthood South Atlantic, United States v. Skrmetti, and Kennedy v. Braidwood Management, Inc., *which illustrate how courts have restricted patient and provider autonomy, treated medical uncertainty as a justification for intervention, and weakened the independence of expert advisory committees.*

We are concerned about this trend of "encroachment" because it risks worsening patient outcomes, chilling appropriate care, and obstructing continued research. To address this issue, we propose rebuilding trust through stronger professional accountability, transparency, public education, and

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engagement with dissenting views, while urging political actors to employ scientific methods and collaborate with medical experts when developing healthcare policy.

INTRODUCTION

A self-regulating "profession" sets and maintains the standards of education and training that govern entry and practice. For much of United States history, the medical profession was largely able to self-regulate. Doctors controlled who could practice and what were appropriate choices or bounds within medical decision-making. Physician licenses that allowed the practice of medicine, while issued by governmental agencies, were largely controlled and directed by state boards of medicine and their physician members. Medical societies, essentially guilds of medical professionals, published best practices and guidelines. The legal system has often adopted these best practices and guidelines as legal standards for the profession in medical malpractice cases. In general, clinical practice guidelines submitted to courts as evidence work to establish the legal standard of care over time. In addition, the new American Law Institute *Restatement (Third) of Torts: Medical Malpractice*, approved in 2024, more explicitly permits practice guidelines as evidence of the standard of care for medical-malpractice litigation.[1] The medical profession's ability to self-regulate has not historically been total—state governments have always regulated healthcare through their police power to protect general public welfare and promote safety. But the profession has been a significant structural force in our healthcare system.

In the last several years, however, we have seen a dramatic erosion of the medical profession's ability to self-regulate, particularly when an area of medicine becomes stigmatized or politically controversial. Federal and state governmental actors—including state legislators, state attorneys general, judges, Congress, and presidential administrations—have caused this erosion.

Two major events accelerated this encroachment upon the medical profession. The first was the challenging COVID-19 pandemic, during which

1. *See Torts: Medical Malpractice Is Approved*, A.L.I. (May 21, 2024), https://www.ali.org/news/articles/alis-torts-medical-malpractice-approved [https://perma.cc/M6EG-MU7Y]; RESTATEMENT (THIRD) OF TORTS: MEDICAL MALPRACTICE § 6(b) (A.L.I. 2024) ("Establishing Breach of, or Compliance with, the Standard of Care . . . (b) Evidence that the provider complied with a relevant and authoritative practice guideline may be: (1) used to rebut the plaintiff's claim that the provider breached the standard of care as provided in § 5; or (2) sufficient to find that the provider met an acceptable alternative standard of care, as provided in § 5, Comment *k*.").

communications and handling by public health leaders eroded the trust of the general public and lawmakers in scientific and medical evidence. The second was the decision of *Dobbs v. Jackson Women's Health Organization*, the case that was intended to "return the issue of abortion to the people's elected representatives" and allow "the States [to] regulate abortion for legitimate reasons."[2] *Dobbs* created an opportunity for states to treat one area of healthcare as an arena in which to express their political positions rather than following physician expertise,[3] setting a precedent that would leave less and less room for the medical profession to self-regulate.

The post-*Dobbs* abortion lawfare has normalized government intrusion into what has traditionally been the province of the medical profession: determining what is appropriate care to offer patients. What these encroachment actors have in common is that they are not medical bodies or practitioners; they do not seek "Gold Standard" medical evidence for making decisions about regulation (although they sometimes use those words to lend legitimacy to their actions).[4] They instead act out of political motivation.[5] Ultimately, this encroachment trend is concerning because it undermines the ability of physicians to determine and provide appropriate care. The impact on individual patients may be that the care they need is withheld, denied, or inaccessible if insurance coverage is unavailable. Over time, such encroachment also prevents the improvement of medical practices for all by making it impossible to incorporate and study the outcomes of evidence-based practices in medical care.

There is value in government action to preserve or implement evidence-based medical standards and physicians' professional autonomy. That approach has been fundamentally different from the recent phenomenon of substituting ideology for scientific judgment. Our overarching concern is that state authority should not be used to undermine evidence-based standards developed over time and overseen by medical experts.

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2. 597 U.S. 215, 232, 300 (2022).

3. Kevin O'Reilly, *AMA Holds Fast to Principle: Reproductive Care Is Health Care*, AMA (Nov. 17, 2022), https://www.ama-assn.org/public-health/population-health/ama-holds-fast-principle-reproductive-care-health-care [https://perma.cc/F3XU-GULY].

4. Exec. Order No. 14,303, 90 Fed. Reg. 22601, 22601 (May 29, 2025) [hereinafter *Executive Order: Restoring Gold Standard Science*].

5. Joshua M. Sharfstein, *What Could Be Wrong with "Gold Standard Science"?*, MILBANK MEM'L FUND (Oct. 30, 2025), https://www.milbank.org/quarterly/opinions/what-could-be-wrong-with-gold-standard-science [https://perma.cc/PKH3-3PDD].

This Feature first documents the self-regulating nature of the medical profession, including its evolution, the key tools it uses to set boundaries and achieve consensus (such as the scientific method), and long-standing critiques of this system. The Feature then provides a nonexhaustive landscape of recent encroachment efforts from federal and state political and legal actors. Using this snapshot, we explain that these encroachment efforts are concerning because they substitute state judgments for the combination of medical expertise and patient personal preferences that are expressed in provider-patient medical decision-making. Lastly, we evaluate recent responses from medical actors, including professional societies. We also provide solutions for rebalancing the medical and political/legal systems.

In contrasting political actors with medical actors, we acknowledge that clinical medicine and clinical research operate within political systems and are influenced by them, for better or for worse.[6] For example, government actors may act to address bias in medical practice by improving the inclusion of women and nonwhite racial groups in research.[7] Conversely, government officials may question the very premise that clinical research

6. *See generally* DANIEL E. DAWES, THE POLITICAL DETERMINANTS OF HEALTH (2020) (Dawes argues that political determinants of health create social drivers that include but are not limited to: poor environmental conditions, inadequate transportation, unsafe neighborhoods, and lack of healthy food options. These social drivers, the result of political systems, affect all other dynamics of health); Diana Montoya-Williams & Elena Fuentes-Afflick, *Political Determinants of Population Health*, JAMA NETWORK OPEN (July 19, 2019), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2738341 [https://perma.cc/GXA2-NGLP] (arguing about the implications of a study of preterm birth and asserting the study raises questions about the association between sociopolitical events and population health); Marc A. Rodwin, *The Politics of Evidence-Based Medicine*, 26 J. HEALTH POL. POL'Y & L. 439, 439-46 (2001) (arguing that as evidence-based medicine is used to oversee individual physicians and the practice of medicine, it thus helps to "alter the balance of power among doctors, payers, and patients").

7. *See generally NIH Policy and Guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research*, NAT'L INSTS. HEALTH (July 21, 2025), https://grants.nih.gov/policy-and-compliance/policy-topics/inclusion/women-and-minorities/guideline [https://perma.cc/BRH6-L6X5] (updating the NIH Revitalization Act of 1993, Pub. L. No. 103-43, 107 Stat. 122 (1993), which "directed the NIH to establish guidelines for inclusion of women and minorities in clinical research").

and medical expertise lead to excellent medical practice.[8] We do not argue that medicine is apolitical or could or should be untouched by government action; rather, we describe recent political actions that are at odds with excellent medical practice. Given the impact and aftermath of COVID-19 and *Dobbs*, and the need to build back protection from further encroachment by political actors, we emphasize both rebuilding trust in the medical profession itself and encouraging the relevant government actors to better engage with scientific data and methodology in collaboration with medical experts.

I. HISTORY OF SELF-REGULATION

The practice of medicine worldwide, as well as in the United States, began without regulation of any meaningful kind. Physicians and surgeons practiced within guilds according to their own,[9] frequently erroneous, concepts of health and illness. Early practice was haphazard with unsurprisingly poor outcomes.[10] In the United States, the dominant form of medical education until the latter half of the nineteenth century was an

8. *See generally* Brooke McCormick, *NIH Grant Terminations Disrupt 1 in 30 Clinical Trials, Impacting Over 74,000 Participants*, AM. J. MANAGED CARE (Nov. 17, 2025), https://www.ajmc.com/view/nih-grant-terminations-disrupt-1-in-30-clinical-trials-impacting-over-74-000-participants [https://perma.cc/7USE-4RWU] (describing termination by Trump administration of National Institutes of Health grants that do not align with the administration's priorities, including COVID-19 and diversity, equity, and inclusion efforts); Wendy E. Wagner, *How Not to Design Expert Bureaucracy: Lessons from Administrative Law*, 104 N.C. L. REV. 111 (2025) (discussing Trump's executive order that delegates the authority to determine what "gold standards" of science mean for agency decision-making as the administration moves away from well-accepted methods of scientific inquiry).

9. *See generally* Eugène J.F.M. Custers & Olle ten Cate, *The History of Medical Education in Europe and the United States, with Respect to Time and Proficiency*, 93 ACAD. MED. S49 (2018) (tracing the evolution of medical education in Europe and the United States, highlighting a shift from unstructured, time-variable training to competency-based models).

10. *See generally* Sylvia R. Cruess & Richard L. Cruess, *The Medical Profession and Self-Regulation: A Current Challenge*, VIRTUAL MENTOR, Apr. 2005, https://journalofethics.ama-assn.org/article/medical-profession-and-self-regulation-current-challenge/2005-04 [https://perma.cc/KXF7-2RFY] (providing a history of self-regulation in support of their argument that the medical profession's social contract is threatened by failing to adequately self-regulate).

extended apprenticeship, and not formal schooling.[11] Indeed, until 1810, the United States had only three medical schools, and even at the end of the nineteenth century, the standard medical school curriculum was only two years long.[12]

Beginning in the mid-nineteenth century, professionalized medical practice and investigation began to come to the forefront, with published research documenting improving outcomes and standard procedures.[13] Medical professionals formed governing organizations like the American Medical Association to collect, summarize, and distribute medical knowledge and best practices.[14] This was coupled with increasing standardization and requirements for medical education, both at medical school and in internship programs.[15] The result of these developments was an elevated status for the medical profession. As Paul Starr notes in his seminal history of medicine:

> The medical profession has had an especially persuasive claim to authority. Unlike the law and the clergy, it enjoys close bonds with modern science, and at least for most of the last century, scientific knowledge has held a privileged status in the hierarchy of belief.[16]

Starr links the authority of medical professionals to their status as "representative[s] of a community of shared standards," and explains that "[t]he basis of those standards in the modern professions is presumed to be rational inquiry and empirical evidence," along with "an orientation to specific, substantive values—in the case of medicine, the value of health."[17] Of course, this drive to shared standards and values, including standardized education and credentials, was also in part exclusionary, creating serious barriers for people of color and women seeking to take part in the shared

11. *See generally* AMERICAN MEDICAL SCHOOLS AND THE PRACTICE OF MEDICINE: A HISTORY (William G. Rothstein ed., 2010) (providing a comprehensive history tracing the evolution of U.S. medical education from the late 18th century to the late 20th century).

12. Custers & Cate, *supra* note 9, at S51.

13. Cruess & Cruess, *supra* note 10.

14. Cruess & Cruess, *supra* note 10.

15. Custers & Cate, *supra* note 9, at S51.

16. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION & THE MAKING OF A VAST INDUSTRY 4 (2d. ed. 2017).

17. *Id.* at 12.

profession.[18] But the existence of medicine as profession, including its power to exclude for both legitimate and problematic reasons, was only possible because of the shared structure focusing on the modern scientific method that was developed in the latter half of the nineteenth century and the first half of the twentieth century.

The respect for the medical profession, perhaps at its height at the start of the twentieth century, helped shape the regulatory framework for the practice of medicine and health law overall.[19] In this same time frame, society expressed its respect for the medical profession with the advent of licensing laws, aimed at allowing the medical profession itself to gatekeep its boundaries. Medical professionals argued persuasively that their approach to practice and documentation resulted in better outcomes than those achieved from alternative means. In addition, they asserted that the

18. An example of using professional standards to exclude people of color from the privilege and power of the medical profession can be found in the 1910 Flexner Report, which was designed to assess the quality of all the American medical schools with a goal of eliminating the "over-production of uneducated and ill-trained medical practitioners." *See generally* ABRAHAM FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA: A REPORT TO THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING (1910). Abraham Flexner discounted the need of the Black community to be served by Black physicians, imposed his own biased opinion on assessing the quality of Black medical students, assumed Black physicians would never treat white patients, and harshly graded medical schools dedicated to educating Black students. *See generally* Yasmeen Daher et al., *The History of Medical Education: A Commentary on Race*, 121 J. OSTEOPATHIC MED. 163 (2021) (a history of medical education with a focus on race and references to racism in the Flexner report). As a direct result of the Flexner Report, all but two of these medical schools closed, significantly limiting the opportunity for Black students to enter the medical profession during this time. *See generally* Terri Laws, *How Should We Respond to Racist Legacies in Health Professions Education Originating in the Flexner Report?*, 23 AMA J. ETHICS 271 (2021) (noting that disproportionate rates of illness and death experienced by Black, Latin, and Native Americans during the COVID-19 pandemic drew attention to a need for curricular change in medical education that will take time).

19. *See generally* Sara Rosenbaum, *The Impact of United States Law on Medicine as a Profession*, 289 JAMA 1546 (2003) (examining how the evolution of United States law has influenced medicine as a profession, and giving a series of examples, including the evolution of the no-duty-to-treat principle, the standards of medical liability, and the basic loss of highly preferential treatment under U.S. laws aimed at preventing anticompetitive conduct by businesses).

complex knowledge and skill required made regulation solely by nonprofessionals impractical.[20]

Thus, society and those providing medical services entered into a "social contract" with "reciprocal rights and obligations."[21] This theoretical contract contemplated that "[i]n return for a physician's commitment to altruistic service, a guarantee of professional competence, the demonstration of morality and integrity in their activities, and their agreement to address issues of social concern, society grant[ed] to both individual physicians and the profession considerable autonomy in practice, status in the community, [and] financial rewards."[22] Breaches of these standards—such as unethical, immoral, or incompetent practices—were met with remediation or discipline. This was the basis for "self-regulation" within medicine. A parallel process was achieved in law.[23]

A. Evolution into the Current Form of Self-Regulation

One primary method physicians employ to maintain their right to the continued social contract of self-regulation described above is to create and maintain a high standard of education, certification, and medical research,[24] with demonstrated improved and improving outcomes in remediation of disease. This educational, certification, and research "process" in medicine in the United States has changed considerably over the years as it has become more rigorous and standardized.[25] Only as recently as the 1980s

20. Cruess & Cruess, *supra* note 10.

21. *Id.*; *see also* Rosenbaum, *supra* note 19, at 1555 ("[L]egislation, such as laws that guarantee access to external review of corporate treatment decisions, all point to an enduring concern on the part of society . . . that reforms aimed at holding the medical profession accountable to society in terms of access, cost and quality of health care must proceed with caution to preserve the medical profession's fundamental integrity.").

22. *Id.*

23. *See generally* Fred C. Zacharias, *The Myth of Self-Regulation*, 93 MINN. L. REV. 1147, 1148-49, 1155 (2008) (noting that despite extensive apparent regulation, courts, commentators, and legal ethics regulators continue to conceptualize law as a "self-regulated profession," and exploring whether law is truly self regulated).

24. *See generally* Custers & Cate, *supra* note 9.

25. *Id.* at S51-52.

have physicians implemented a fully standardized and empirically evaluated system of postgraduate medical education in the United States governed by a national body determining length, content, and qualifications for entry.[26] The goal of such a system is not only to ensure quality medical and surgical care, but also to maintain public trust in the profession's decision to maintain this "social contract" of self-regulation.

To practice medicine in the United States, clinicians today must complete a four-year course of study to obtain a doctorate of medicine or osteopathy. This training includes basic didactic learning and between two and three years of practicum, which involves actively caring for patients in a limited way under supervision. From there, physicians "match" into a "residency," so named because originally these doctors in training lived on site at training hospitals. Residencies focus on a particular area of practice, such as pediatrics, internal medicine, or a discipline in surgery. Residents directly care for patients while under supervision and form an essential part of the healthcare workforce. Many physicians further subspecialize with fellowship training, an extension of residency.[27]

During medical school and extending into residency, students must pass their school exams and complete four sets of United States Medical Licensing Exams.[28] During residency, they must meet minimum guidelines of experience, skills, and professionalism as defined by the Accreditation Council for Graduate Medical Education, the national body referenced above.[29] After residency, physicians and surgeons can practice independently as they have completed steps for the medical license, but most hospital systems require that they pass "boards," an exam with both written and oral components. Boards are run by professional medical societies, like the American Board of Internal Medicine.[30] After passing, a physician is "board certified." Thereafter, physicians maintain board

26. *Id.* at S52.

27. Brandon T. Grover & Shanu N. Kothari, *Fellowship Training: Need and Contributions*, 96 SURGICAL CLINICS N. AM. 47, 47-48, 53 (2016) (describing the course of study and qualifications necessary to become a surgeon).

28. *About the USMLE*, U. S. MED. LICENSING EXAMINATION, https://www.usmle.org/about-usmle [https://perma.cc/NU6U-4MCR].

29. *About the ACGME*, ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., https://www.acgme.org/about/overview [https://perma.cc/8SBR-RUUR].

30. *Member Boards: Specialty and Subspecialty Certificates*, AM. BD. MED. SPECIALTIES, https://www.abms.org/member-boards/specialty-subspecialty-certificates/ [https://perma.cc/6F7D-3P3B].

certification through "maintenance" study and testing on a yearly basis. All aspects of this training process, with the exception of maintaining board certification, have been vetted and shown to result in higher levels of care.[31]

States impose additional layers of oversight. Each physician must be licensed by the state. State medical boards issue these licenses.[32] The state boards are typically composed primarily of physicians but many also include members of the public, meaning that they operate largely as an expression of the medical profession.[33] Boards hear complaints and can suspend or revoke licenses.[34] Hospitals evaluate physicians and issue "privileges" commensurate with level of training and peer reviews of competence.[35] These privileges are evaluated yearly or at slightly longer intervals. Hospitals must report transgressions or negligence pursuant to various statutory mandates, but they handle internally any variance from expected levels of care that does not rise to the level of mandatory reporting to the board.[36] Patients may lodge complaints with hospitals, state medical boards, and/or national specialty boards.[37] Finally, patients may resort to a

31. *See generally* Tim Xu et al., *Association Between Board Certification, Maintenance of Certification, and Surgical Complications in the United States*, 34 AM. J. MED. QUALITY 545 (2019) (using national Medicare claims to study the association between board certification and completion of Maintenance of Certification ("MOC") requirements and surgeon rates of complications for 8 elective procedures; finding that board-certified surgeons were less likely to be outliers but completion of MOC was not associated with differences in complication rates).

32. FED'N STATE MED. BDS., https://www.fsmb.org [https://perma.cc/GU3R-LVJ2].

33. David A. Johnson, Katie L. Arnhart, Humayun J. Chaudhry, David H. Johnson & Graham T. McMahon, *The Role and Value of Public Members in Health Care Regulatory Governance*, 94 ACAD. MED. 182, 182 (2019).

34. *About Physician Discipline*, FED'N STATE MED. BDS., https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-discipline [https://perma.cc/YAE9-KD2U].

35. Gary L. Freed, Kelly M. Dunham & Dianne Singer, *Use of Board Certification and Recertification in Hospital Privileging: Policies for General Surgeons, Surgical Specialists, and Nonsurgical Subspecialists*, 144 ARCHIVES SURGERY 746, 746-47 (2009).

36. *See generally* Joel M. Geiderman & Catherine A. Marco, *Mandatory and Permissive Reporting Laws: Obligations, Challenges, Moral Dilemmas, and Opportunities*, 1 JACEP OPEN 38 (2020) (discussing mandatory and permissive reporting laws).

37. *See, e.g.*, *Patient Rights & Responsibilities*, BETH ISRAEL DEACONESS MED. CTR., https://bidmc.org/patients-visitors/rights-responsibilities

legal complaint alleging medical malpractice. In this scenario, while a judge and/or jury will be charged with determining if a physician met a certain standard of care, that standard is typically defined by medical experts who provide testimony and describe the standard based primarily on medical evidence and guidelines crafted by national medical societies.[38]

Even when medical practice is governed primarily by physician self-regulation, governments still retain an ongoing interest in its oversight. States, especially state governments, have a traditional role in regulating the health and safety of their populations. State medical boards are a collaboration between the state and the profession to ensure self-regulation proceeds with the interests of the public placed centrally. The state provides licenses and oversight to hospitals typically through Joint Commission accreditation.[39] The Joint Commission is an independent organization tasked with periodic reviews of hospitals. Reviews are led onsite every twenty-four to thirty-six months by clinicians and address target areas such as hygiene and adherence to published, established standards.[40] State departments of public health play a strong role in research and setting guidelines for practice. Yet, all actions by departments of public health and state medical boards have been traditionally guided by medical evidence.[41]

[https://perma.cc/X9GZ-CNZR] (explaining where a patient may submit a complaint).

38. Daniel G. Aaron, Christopher T. Robertson, Louise P. King & William M. Sage, *A New Legal Standard for Medical Malpractice*, 333 JAMA 1161, 1162-63 (2025).

39. JOINT COMM'N, https://www.jointcommission.org/en-us [https://perma.cc/6NFQ-HQDE].

40. *Accreditation Process*, JOINT COMM'N, https://www.jointcommission.org/en-us/accreditation/process [https://perma.cc/D3DL-EAKL]

41. *See generally Evidence-Based Public Health*, ASS'N STATE & TERRITORIAL HEALTH OFFS., https://www.astho.org/topic/evidence-based-public-health [https://perma.cc/AY9Y-D6TQ] (providing technical assistance to public health entities through "packages [that] integrate public health and medical practices rooted in peer-reviewed science and evidence, creating a stronger foundation for public health practice"); *FSMB Policies and Regulatory Resources*, FED'N STATE MED. BDS., https://www.fsmb.org/advocacy/policies-and-regulatory-resources [https://perma.cc/DT4E-3J2T] (providing guidance to state medical boards that explicitly incorporates evidence-based treatment and science-grounded practice); WHO WILL KEEP THE PUBLIC HEALTHY? EDUCATING PUBLIC HEALTH PROFESSIONALS FOR THE 21ST CENTURY 145-167 (Kristine M. Gebbie, Linda Rosenstock & Lyla M. Hernandez eds., 2003) (emphasizing that public health agencies are critical partners in educating the

This history and modern expression show a central component of self-regulation: defining the evidence-based standard of care, ensuring all professionals practice within that standard, and articulating acceptable degrees of experimentation within the scope of practice in order to expand or change the standard and achieve improved outcomes. In this way, when the system works as planned, the profession continues to prioritize the health and well-being of patients as its central concern in fulfilling the "social contract." Ensuring that the standard of care is well-defined requires a formalized method of scientific exploration.

B. Evidence-Based Medicine, the Scientific Method, and Their Limitations

Evidence-based medicine is "an explicit process for clinical practice decision-making in individual patients . . . [that] requires the integration of a physician's clinical expertise with the best available medical evidence obtained from systematic research."[42] The process by which modern medicine defines evidence-based care is well established.[43] The scientific method is the process of objectively establishing facts through testing and experimentation. This method requires rigorous adherence to the principles of statistics and epidemiology. "Levels of evidence" define which evidence can be relied upon in determining the best course of care.[44] This is a hierarchical system that ranks the quality and strength of research findings, with randomized controlled trials, systematic reviews, and meta-analyses ranked as some of the most reliable forms of evidence, and expert opinions as the least reliable. In some areas of medicine, only expert opinion

physician workforce by fostering academic-practice partnerships, mentoring staff, improving field experience for students, and ensuring leadership holds Masters in Public Health–level education or expertise in ecological approaches).

42. Stephen Chris Pappas, *Curing the* Daubert *Disappointment: Evidence-Based Medicine and Expert Medical Testimony*, 46 S. TEX. L. REV. 595, 599 (2004).

43. *See generally* NAT'L ACADS. OF SCIS., ENG'G & MED., *Scientific Methods and Knowledge*, *in* REPRODUCIBILITY AND REPLICABILITY IN SCIENCE 160 (2019) (discussing the nature of science and the scientific process, specifically how scientists accumulate scientific knowledge through discovery, confirmation, and correction and highlight the process of statistical inference).

44. Sowdhamini S. Wallace, Gal Barak, Grace Truong & Michelle W. Parker, *Hierarchy of Evidence Within the Medical Literature*, 12 HOSP. PEDIATRICS 745, 746 (2022).

is available, but the goal is always to achieve the highest and most reliable forms of evidence. Unfortunately, robust randomized trials are expensive and, at times, depending on the question presented, impossible to achieve.[45]

While the scientific method does not always arrive at a definitive answer or path forward to the best care options, it does so the majority of the time. Over the past 150 years, the progress in safety and improvement in quality of life attributed to medicine and the scientific method has been exponential.[46] Progress in antibiotics, imaging, diagnostics, therapeutics, and surgical techniques has led to unprecedented benefits. Yet, many questions remain unanswered, and some answers may later be found false or biased.

Scientific studies conducted with patients are frequently marred by confounders (or confounding variables), which are external variables that distort the true relationship between the variables being studied, leading to incorrect conclusions. For example, a study of a particular medication may demonstrate an effect that we attribute to the medication, even though it is actually a result of a confounding variable not related to the medication. Researchers attempt to control for confounders using methods like randomization in study design or statistical techniques like matching and stratification to eliminate or adjust for their effects, but no study is perfect. Bias affects how we design studies and create algorithms from our findings to help us treat patients. A classic recent example of bias at play is reflected in our current work to undo algorithms that inappropriately used race as a determinative value and have denied care to Black patients seeking dialysis or kidney transplant and those seeking to have a vaginal birth after cesarean.[47] Researchers and clinicians potentially bias studies and clinical

45. *Oxford Center for Evidence-Based Medicine: Levels of Evidence (Mar. 2009)*, CTR. FOR EVIDENCE-BASED MED., https://www.cebm.ox.ac.uk/resources/levels-of-evidence/oxford-centre-for-evidence-based-medicine-levels-of-evidence-march-2009 [https://perma.cc/R78W-BCEX]; Patricia B. Burns, Rod J. Rohrich & Kevin C. Chung, *The Levels of Evidence and Their Role in Evidence-Based Medicine*, 128 PLASTIC RECONSTRUCTIVE SURGERY 305, 308 (2011).

46. Atul Gawande, *The Score*, NEW YORKER (Oct. 9, 2006), https://www.newyorker.com/magazine/2006/10/09/the-score.

47. Salman Ahmed et al., *Examining the Potential Impact of Race Multiplier Utilization in Estimated Glomerular Filtration Rate Calculation on African American Care Outcomes*, 36 J. GEN. INTERNAL MED. 464, 466 (2021); Nicholas Rubashkin et al., *Automating Racism: Is Use of the Vaginal Birth After Cesarean Calculator Associated with Inequity in Perinatal Service Delivery?*, J. RACIAL & ETHNIC HEALTH DISPARITIES 13, 146 (2024).

"calculators" in part by not recognizing how our racial biases result in confounding.

Patients are frequently frustrated with lack of progress and poor outcomes in individual cases. This frustration contributes to patients more frequently turning to alternative and frequently unscientific therapies.[48] Misinformation and other unsupported claims increasingly mislead people in search of alternative approaches to care. It can be difficult for anyone not educated in statistics and medical evidence to understand the nuance of expected failure rates and distinguish those from outright bias or poor evidence as described above.

Stated another way, few medical interventions are designed or expected to work for every patient every time. Yet, some medical therapies and interventions go beyond this expected variance in patient outcomes and suffer from flawed designs. Distinguishing between these two categories of medical therapies for the public is important work that the medical profession could stand to improve upon. Medical professionals as a group have not done enough to maintain the trust of the public either through outright abuses as described below, or simply through poor communication

48. Examples of recent, popular alternative approaches include: parental rejection of the measles, mumps, and rubella vaccine and other vaccines, *see, e.g.*, Saad B. Omer et al., *Trends in Kindergarten Rates of Vaccine Exemption and State-Level Policy, 2011–2016*, OPEN F. INFECTIOUS DISEASES, Feb. 2018, at 1, 5 (reporting an increase in nonmedical exemption rates through the 2012-2013 school year; and noting that rates stabilized through the 2015-2016 school year, showing an important shift in trend); *see generally* Eve Dubé, Maryline Vivion & Noni E. MacDonald, *Vaccine Hesitancy, Vaccine Refusal and the Anti-Vaccine Movement: Influence, Impact and Implications*, 14 EXPERT REV. VACCINES 99 (2015) (examining determinants of parental decision-making about vaccination and an overview of the history of antivaccination movements and their clinical impact), the popularity of alternative therapies for cancer treatment, Melissa Dahl, *The Inner Voice vs. the Oncologist*, CUT (May 27, 2025), https://www.thecut.com/article/breast-cancer-treatment-natural-remedy-alternative-medicine.html [https://perma.cc/GCL6-CAY9]; Matt Hongoltz-Hetling, *The Story of One Woman Who Fell Prey to the Medical Freedom Movement*, N.Y. TIMES (Mar. 29, 2025), https://www.nytimes.com/2025/03/29/opinion/medical-freedom-cancer-rfk.html, and the movement to supplant traditional reproductive medicine with restorative reproductive medicine. Bindu Bansinath, *What Is 'Restorative Reproductive Medicine'?*, CUT (Aug. 21, 2025), https://www.thecut.com/article/restorative-reproductive-medicine-ivf-alternative-explained.html [https://perma.cc/37R9-6GQD].

or lack of empathy. Thus, their attempts to claim a position of expertise are severely undermined.

C. Persistent Critiques of Self-Regulation and Loss of Trust

Despite repeatedly avowing a desire to adhere to the highest levels of evidence in altruistic practice, there are multiple examples both historically and currently of the medical profession failing to adhere to this standard. Trust in the medical profession has understandably suffered greatly and this trust continues to wane. Some examples include outright abuses and failures to adhere to the professed commitment to putting patients first, such as decades of studies in Tuskegee of Black men with curable syphilis.[49] This historical legacy, coupled with fewer quality interactions with the medical profession, continues to contribute to lower rates of trust in Black patients as compared to white patients.[50] Other examples involve a failure in scientific rigor, such as failures in exploring the dangers of thalidomide ahead of widespread use leading to severe deformities in fetuses and newborns.[51] Still others involve systemic issues related to a lack of funding and prioritization of marginalized and vulnerable groups, including the failure to adequately account for and fund research for women's health.[52]

A tension naturally exists when a group seeks to regulate its own behavior. Such a system requires the trust of societal members and continuous proof that this trust is maintained and earned. As described above, multiple examples exist of the medical profession missing this mark.

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49. *See generally* SUSAN M. REVERBY, EXAMINING TUSKEGEE: THE INFAMOUS SYPHILIS STUDY AND ITS LEGACY 4 (2009) (investigating the Tuskegee study, its aftermath from multiple perspectives, and the reasons for its continued power and resonance in our collective memory).

50. *See* Chanita Hughes Halbert, Katrina Armstrong, Oscar H. Gandy, Jr. & Lee Shaker, *Racial Differences in Trust in Health Care Providers*, 166 ARCHIVES INTERNAL MED. 896, 898 (2006) (finding from a national survey of 954 non-Hispanic adult African Americans that when compared with whites, African Americans were more likely to report low trust in health care providers).

51. *About Thalidomide*, THALIDOMIDE TRUST, https://thalidomidetrust.org/about-us/about-thalidomide [https://perma.cc/QX9F-7DQK].

52. *Ethical Considerations for Increasing Inclusivity in Research Participants*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2024/06/ethical-considerations-for-increasing-inclusivity-in-research-participants [https://perma.cc/4BAX-CT57].

More recently, many members of the profession have engaged in misinformation in direct violation of our ethical codes and guidance from various professional organizations, yet few have faced repercussions.[53] The most recent and most dramatic example of this involved medical professionals espousing unproven and dangerous treatments during the COVID pandemic.[54]

With this background, it is perhaps not unexpected that while the medical profession has always faced judicial/legislative threats of encroachment, current assaults far exceed those of the past. For much of the profession's recent history, the state maintained a role in regulating general health and safety. Within the discipline of public health, this role was originally defined in collaboration with the medical profession, as evidenced by the quintessential story of John Snow and the Broad Street pump.[55] When faced with a cholera epidemic in London, in the 19th century, Snow conducted pioneering investigations and demonstrated that contaminated water was the key source. His investigation of an outbreak in the Soho district of London led to his conclusion that contaminated water from the Broad Street pump was the source of the disease. The state then agreed to remove the pump handle, leading to cessation of the outbreak.[56] This story is still taught in medical school today, as an example of the scientific method being applied to empirically determine the root cause of disease, propose an effective solution or treatment, and thereafter to implement this broadly through state action. At the time, public health officials did not believe Snow's explanation of the source of disease, instead

53. *See generally* Y. Tony Yang & Sarah Schaffer DeRoo, *Disciplining Physicians Who Spread Medical Misinformation*, 28 J. PUB. HEALTH MGMT. & PRAC. 595 (2022) (exploring harms of misinformation, distinction from treating individual patients, and the need for continued free speech protections).

54. Claudia E. Haupt, *Pseudo-Professional Advice*, 103 B.U. L. REV. 775, 778 (2022).

55. The focus of this paper is primarily on the United States. The disciplines of medicine and public health, however, are not tightly constrained by national boundaries. Discoveries in medicine and public health that originate in the United Kingdom or Europe can have immediate influence in the United States and vice versa. The discipline of public health is so closely linked with this particular story of John Snow that a pump is the typical image used to identify the discipline, as a stethoscope, caduceus or knife might be for medicine or a gavel for law. Therefore, we have chosen to include it despite its depiction of events outside the United States.

56. *See* Theodore H. Tulchinsky, *John Snow, Cholera, the Broad Street Pump; Waterborne Diseases Then and Now*, *in* CASE STUDIES IN PUBLIC HEALTH 77, 78 (2018).

believing disease arose in "miasma" all around us, but they deferred to his expertise and removed the pump handle.[57]

As recent abuses, misinformation, scientific failures, and underfunding have eroded trust in scientific expertise, political efforts have been directed at undermining self-regulation. Within the domain of reproductive medicine, evidence of this trend was first seen dramatically during debates around "partial birth abortion." In 2003, Congress passed the Partial-Birth Abortion ("PBA") Ban Act.[58] This law purports to prohibit, through vague and inflammatory language,[59] a procedure of intact dilation and extraction. In this procedure, performed infrequently during later stages of pregnancy, typically for medical necessity, surgeons terminate pregnancies while maintaining fetal tissue intact to avoid significant risk of injury to pregnant patients. Under the PBA ban, any physician "who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than 2 years, or both."[60] The law was enacted in 2003, and in 2007 the Supreme Court upheld its constitutionality in *Gonzales v. Carhart*.[61]

The Supreme Court's holding in *Gonzales* hinged on its finding of medical uncertainty over whether the prohibited procedures are ever necessary to preserve a patient's health.[62] The Court found that prior decisions in this sphere had "given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty."[63] Physicians and representatives of national medical organizations took care to note that differing practices and evolving standards around ideal methods for abortion in later stages of pregnancy

57. *John Snow Memorial Pump Marking Historic Cholera Outbreak Reinstalled in Its Original Location*, LONDON SCH. HYGIENE & TROPICAL MED. (July 20, 2018), https://www.lshtm.ac.uk/newsevents/news/2019/john-snow-memorial-pump-marking-historic-cholera-outbreak-reinstalled-its [https://perma.cc/3R95-Q8Z3].

58. Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (codified at 18 U.S.C. § 1531).

59. *ACOG Guide to Language and Abortion*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/contact/media-center/abortion-language-guide [https://perma.cc/4EJ7-QTG3].

60. 18 U.S.C. § 1531(a) (2024).

61. 550 U.S. 124 (2007).

62. *Id.* at 161.

63. *Id.* at 163.

did not equate with "uncertainty."[64] Instead, medical consensus as presented in amicus briefs at the time was clearly in favor of dilation and extraction procedures as a reasonable and safe method. Without access to this method, patients suffer unnecessary complications.[65]

Just seven years earlier, the Court had ruled favorably for the medical profession in *Stenberg v. Carhart*, striking down a similar law in Nebraska.[66] That decision emphasized, through Justice Breyer's opinion, that an "undue burden" existed when those seeking abortion care were deterred by "fear [of] prosecution, conviction, and imprisonment."[67] Justice Stevens, joined by Justice Ginsburg in a concurrence, emphasized that it was impossible "to understand how a State has any legitimate interest in requiring a doctor to follow any procedure other than the one that he or she reasonably believes will best protect the woman in her exercise of this constitutional liberty."[68] This expected balance and deference to both physician and patient to make determinations about safe and appropriate care was clearly under attack in *Gonzales* even if the majority simply noted a difference in the wording from the *Stenberg* statute.[69]

National organizations including the American College of Obstetrics and Gynecology ("ACOG") reacted strongly to the *Gonzales* opinion, seeing dangers for medical professionals and for the public. ACOG argued that the effect would be chilling, stifling the availability of the safest options for care and preventing patients from seeking care.[70] In an opinion piece in the *New England Journal of Medicine*, George Annas of Boston University Law School

64. Brief of the American College of Obstetricians and Gynecologists as Amicus Curiae Supporting Respondents, Gonzales v. Carhart, 550 U.S. 124 (2007) (No. 05-380).

65. *See* Elizabeth A. Hoffman et al., *Outcomes After Induction of Labor Compared with Dilation and Evacuation for the Management of Rupture of Membranes in the Second Trimester*, 143 OBSTETRICS & GYNECOLOGY 550, 552 (2024) (finding that in a "retrospective cohort study of patients with rupture of membranes between 14 0/7 and 23 6/7 weeks of gestation more than half (52.2%) of those undergoing induction of labor, compared with 16.9% of those undergoing [dilation and extraction] had an adverse event").

66. 530 U.S. 914, 922 (2000).

67. *Id.* at 945.

68. *Id.* at 946.

69. Gonzales v. Carhart, 550 U.S. 124, 149-50 (U.S. 2007).

70. Lucia Pizzo, *Gonzalez v. Carhart* Overview, EBSCO (2019), https://www.ebsco.com/research-starters/law/gonzales-v-carhart#full-article [https://perma.cc/UWZ8-Q9EV].

summarized concerns: "Until this opinion, the Court recognized the importance of not interfering with medical judgments made by physicians to protect a patient's interest. For the first time, the Court permits congressional judgment to replace medical judgment."[71]

The shift in reasoning and deference between *Stenberg* and *Gonzales* foreshadowed the current legal/political encroachment on the medical profession's ability to self-regulate and care for patients to the best of its ability. While the medical profession can be said to be responsible for some of the loss of trust that underlies this change, the pendulum has swung violently away from evidence-based recommendations and legislation, with strong potential for public harm.

II. Recent Encroachment on the Medical Profession

A. Problems with Government Encroachment

Before examining recent encroachments on the medical profession, it is useful to clarify what is meant by "encroachment" and why it is cause for concern. "Encroachment" is not simply any governmental action that impacts healthcare and the choices available to physicians. Government involvement in healthcare and public health can be appropriate. A commonly stated truism is that states "possess[] the right to take suitable measures for the preservation of the health of their citizens" as part of the police power.[72] In *Jacobson v. Massachusetts*, Justice Harlan justified Massachusetts's smallpox vaccine mandates as stemming from:

> the social compact that the whole people covenants with each citizen, and each citizen with the whole people, that all shall be governed by certain laws for "the common good," and that government is instituted "for the common good, for the protection, safety, prosperity and happiness of the people, and not for the profit, honor or private interests of any one man . . . ."[73]

71. George J. Annas, *The Supreme Court and Abortion Rights*, 356 New Eng. J. Med. 2201, 2206 (2007).

72. James A. Tobey, *Public Health and the Police Power*, 4 N.Y.U. L. Rev. 126, 126 (1927).

73. 197 U.S. 11, 27 (1905) (quoting Mass. Const. art. VII). While *Jacobson* was concerned with individual (i.e., the patient's) liberties, the same justifications used by Justice Harlan to balance the rights of the individual against state

When a state is acting to protect the general welfare, such as by requiring healthcare facilities to be licensed and meet certain safety standards, it is acting squarely within its police power to promote general welfare.

Judicial encroachment, however, is the judicial reassigning of medical decision-making from the patient and provider to any governmental entity, whether it be an administrative agency, a state attorney general, Congress, or the court itself. Regulation to promote safety is distinct from controlling the medical profession through acts of judicial encroachment.

The Social Security Act (the "SSA") clearly illustrates the difference between regulation to promote safety and encroachment, as the drafters of the SSA plainly distinguished between the two.[74] The SSA grants the Secretary of the Department of Health and Human Services ("HHS") broad powers to promulgate regulations as needed to administer Medicare and Medicaid, subject to certain important limitations.[75] Most notably, in its opening language, the SSA expressly prohibits any federal interference in the practice of medicine:

> Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.[76]

One of the chief architects of Medicare and Medicaid, Wilbur Cohen, later reflected that this section "was included in the law to offset the criticism made by opponents of the proposal that Federal legislation would give Federal officials the opportunity and right to interfere in the diagnosis and treatment of the individual."[77] That HHS could impose through Medicare and Medicaid "a host of conditions that address the safe and

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regulation are applicable in the balance between physician decision-making and the state.

74. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 42 U.S.C.).

75. 42 U.S.C. § 1302(a) (2024).

76. 42 U.S.C. § 1395.

77. Wilbur J. Cohen, *Reflections on the Enactment of Medicare and Medicaid*, 1985 HEALTH CARE FIN. REV. 3, 8 (1985).

effective provision of healthcare" was reaffirmed as recently as 2022 in *Biden v. Missouri*, in which the Supreme Court determined that requiring healthcare workers to be vaccinated against COVID-19 was a valid patient safety measure, even if it compelled healthcare workers to get medical treatment they objected to.[78]

But why is imposing health and safety requirements on providers permissible state action when regulating diagnosis and treatment (i.e., medical decision-making) is a problematic encroachment? Certainly, promoting health and safety is a worthy task of state actors. However, encroachment poses a problem because it is at cross-purposes with the goal of promoting general welfare and health.

As discussed above, the medical profession has a methodology for developing the appropriate scope of medical care. This methodology uses the scientific method to gather best-available evidence to distill into best practices and recommendations. Physicians are specifically trained in the scientific method so that they can continue to evolve their practices as medical research continues to develop.

Medical uncertainty is a constant in healthcare, and the scientific method, along with evidence-based standards, are designed with that uncertainty in mind. By allowing medical practices to be continually refined while maintaining pressures for the majority of practitioners to comply with current best practices, we maximize the likelihood that medical care is safe and effective. We also leave it to the provider and patient together to arrive at a diagnosis and decide what specific course of treatment is most appropriate in each case, especially when there may be a range of profession-approved practices available.

By contrast, political and regulatory actors struggle to understand scientific evidence and how scientific knowledge continues to evolve. In May 2025, the Administration issued an executive order titled "Restoring Gold Standard Science," with the goal of rebuilding public trust in science and "restoring a gold standard for science to ensure that federally funded research is transparent, rigorous, and impactful, and that Federal decisions are informed by the most credible, reliable, and impartial scientific evidence available."[79] But a gold standard in medicine is impossible, as noted back in 1992, "[b]ecause the subject is in a state of perpetual evolution [such that] gold standards are, by definition, almost, never reached."[80] Gold standards

78. 595 U.S. 87, 94 (2022).

79. *Executive Order: Restoring Gold Standard Science*, *supra* note 4.

80. P. Finbarr Duggan, *Time to Abolish "Gold Standard,"* 304 BRIT. MED. J. 1568, 1568 (1992).

in science imply a universal truth that can end debate "rather than encourage[] a healthy scientific process."[81] This framing speaks to the central problem in state action supplanting the methods the medical profession has used to develop standards of care: A state actor is less likely to be trained to understand scientific research, more likely to be motivated by nonmedical considerations, such as delivering a win to its electoral supporters, and unlikely to continually refine its laws, regulations, and decisions in all areas of medicine. Thus, encroachment undermines the health and general welfare of the population.

In the last several years, we have seen state actors, including the courts, administrative leadership, and legislatures, move away from a focus on health and safety towards encroaching on the ability of the medical profession to self-regulate. In each instance, the state actor intervenes to constrain the choices of the medical providers and the patients and to supplant medical decision-making with the judgment of the state. Section II.B provides a nonexhaustive list of recent encroachments to illustrate the types of attacks occurring on the medical profession's ability to self-regulate.

B. Judicial Encroachment

In the last several years, a series of judicial decisions restricted patients' and providers' ability to engage in appropriate medical decision-making and access evidence-based standards of care. While this paper is concerned with the self-regulation of the medical profession—and thus, the independence of physicians—patients' free decision-making is a necessary component of medical independence. "Shared treatment [decision-making], with its division of labor between physician and patient, is a common ideal in medical ethics for the physician-patient relationship."[82] In the shared decision-making model, the physician "brings an understanding of the effectiveness, benefits, and harms of specific actions and the patient brings an understanding of their preferences and their attitudes to illness and risk."[83] But even further upstream, patient decision-making facilitates the ability of the physician to act: The patient will determine that they have a problem worth consulting with a physician and (within limitations allowed

81. Sharfstein, *supra* note 5.

82. Dan W. Brock, *The Ideal of Shared Decision Making Between Physicians and Patients*, 1 KENNEDY INST. ETHICS J., 28, 28 (1991).

83. Martin Marshall & Jo Bibby, *Supporting Patients to Make the Best Decisions*, 342 BRIT. MED. J. 775, 776 (2011).

by their insurance coverage) determine which physician they would like to work with. If patients are not allowed to seek out certain treatments or providers, then the independence of the medical profession is undermined because the professionals have no one to serve.

The trend to restrict medical independence came into sharp relief with *Dobbs v. Jackson Women's Health*,[84] the case that famously stripped due process protections from abortion care and allowed states to substitute their own judgment on the appropriateness of these services for that of physicians and patients.[85] But the judicial intrusion into the medical profession is not limited to abortion cases, nor is it only a project of the Supreme Court.

1. Supreme Court Judicial Encroachment on the Medical Profession in the October 2024 Term

The October 2024 term of the Supreme Court produced three health-law decisions that illustrate different aspects of judicial encroachment into the medical profession. Each weakened a key aspect of medical independence from legal, regulatory, and political intrusion. *Medina v. Planned Parenthood South Atlantic*,[86] *United States v. Skrmetti*,[87] and *Kennedy v. Braidwood Management, Inc.*[88] are all cases that focus on different types of care and legal questions. But the impact of each case is similar: to limit the freedom that patients and providers have to direct and obtain appropriate medical care. Reading these cases together highlights the trend of judicial encroachment on the medical profession, which reassigns medical-decision-making authority from the medical profession and patients to state actors.

a. *Medina v. Planned Parenthood*

Medina v. Planned Parenthood addressed whether individual Medicaid beneficiaries may sue state officials for failing to comply with Medicaid's

84. Dobbs v. Jackson Women's Health Organization, 597 U.S. 215 (2022).

85. Michael R. Ulrich, *Practicing Medicine in the Culture Wars—Gender-Affirming Care and the Battles over Clinician Autonomy*, 390 NEW ENG. J. MED. 779, 779 (2024).

86. 606 U.S. 357 (2025).

87. 605 U.S. 495 (2025).

88. 606 U.S. 748 (2025).

freedom of choice provision, which ensures that Medicaid beneficiaries can obtain medical assistance from any qualified provider.[89] The Medicaid Act provides that an "individual eligible for medical assistance . . . may obtain [healthcare] from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . ."[90] This provision was passed by Congress in 1967, in response to congressional concern that states were limiting their beneficiaries' access to certain medical providers, even though those providers were qualified.[91]

In 2018, South Carolina attempted to terminate Planned Parenthood from its Medicaid program, despite Planned Parenthood meeting the provider qualification requirements. The Fourth Circuit Court of Appeals repeatedly rejected South Carolina's efforts to remove Planned Parenthood from its Medicaid providers,[92] noting that Medicaid beneficiaries can sue South Carolina state officials to enforce the freedom-of-choice provision.[93] The Medicaid Act itself does not provide authorization for private individuals to sue states in court over their Medicaid choices. Medicaid beneficiaries, however, have tried to use 42 U.S.C. § 1983, commonly referred to as Section 1983, to assert a private right of action.[94] In 2023, for

89. *Medina*, 606 U.S. at 363.

90. 42 U.S.C. § 1396a(a)(23) (2024).

91. Lara Cartwright-Smith & Sara Rosenbaum, *Medicaid's Free-Choice-of-Provider Protections in a Family Planning Context:* Planned Parenthood Federation of Indiana v. Commissioner of the Indiana State Department of Health, 127 PUB. HEALTH REP. 119, 120 (2012).

92. Katie Keith, *Supreme Court Argument:* Medina v. Planned Parenthood, HEALTH AFFS. (Apr. 9, 2025), https://www.healthaffairs.org/do/10.1377/forefront.20250408.310005/full [[https://perma.cc/3Z5L-XG26]

93. Fabiola De Liban & Jane Perkins, Medina v. Planned Parenthood of South Atlantic: *Explainer on the Impact on Medicaid and Sexual and Reproductive Health*, NAT'L HEALTH L. PROGRAM (Jan. 31, 2025), https://healthlaw.org/medina-v-planned-parenthood-of-south-atlantic-explainer-on-the-impact-on-medicaid-and-sexual-and-reproductive-health [https://perma.cc/RCG7-ETNC]. This position was also taken by five other federal courts of appeals, although two other circuit courts decided that the freedom of choice provision could only be enforced by the Department of Health and Human Services.

94. Laurie Sobel & Alina Salganicoff, *SCOTUS Ruling on* Medina v. Planned Parenthood *Will Limit Access to Care for Patients in South Carolina and Beyond*, KAISER FAM. FOUND. (June 27, 2025), https://www.kff.org/policy-watch/scotus-ruling-on-medina-v-planned-parenthood-will-limit-access-to-

example, Medicaid beneficiaries convinced the Supreme Court that another Medicaid provision, designed to protect nursing home residents against negligence and abuse, conferred individual rights on the beneficiaries due to the rights-creating language in the relevant provision, which could be enforced using Section 1983.[95]

In *Medina*, however, Justice Gorsuch, writing for the Court, concluded that the freedom-of-choice provision did not use "clear and unambiguous" rights-creating language to allow for Section 1983 private enforcement.[96] Gorsuch distinguished *Medina* from prior precedent by pointing to a lack of clear and unambiguous rights-conferring statutory language, and therefore concluded that it was the federal government that ought to remedy state misconduct.[97] The federal government, he argued, can terminate funds to punish states: "[T]his Court has called funding cutoffs 'the typical remedy' when a grant recipient violates the terms of spending-power legislation."[98] While Gorsuch acknowledged that the freedom-of-choice provision requires state Medicaid programs to allow access to qualified providers (with exceptions),[99] he did not consider the importance of patients being able to enforce this provision. Gorsuch also did not consider what avenues

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care-for-patients-in-south-carolina-and-beyond [https://perma.cc/9ZJ7-EXU6].

95. Health & Hosps. Corp. of Marion County v. Talevski, 599 U.S. 166, 188-92 (2023).

96. Medina v. Planned Parenthood South Atlantic, 606 U.S. 357, 380 (2025); *see also* Amy Howe, *Court Decides against Planned Parenthood*, SCOTUSBLOG (June 26, 2025), https://www.scotusblog.com/2025/06/court-decides-against-planned-parenthood [https://perma.cc/S8V3-C8V8].

97. *Medina*, 606 U.S. at 365. Just two years prior, in *Health and Hospital Corporation of Marion County v. Talevski*, the Court had concluded that an individual had a private right of enforcement under Medicaid's Federal Nursing Home Reform Act ("FNHRA"). 599 U.S. 166, 172 (2023). But the Court focused on the specific wording of FNHRA as conferring unambiguous rights on individuals and therefore was not broadly applicable to other aspects of Medicaid. *See* Sara Rosenbaum, Timothy Jost, MaryBeth Musumeci & Alexander Somodevilla, *A Victory for Medicaid Beneficiaries in Supreme Court's* Talevski *Decision*, HEALTH AFFS. (June 9, 2023), https://www.healthaffairs.org/do/10.1377/forefront.20230608.363841/full [https://perma.cc/DM46-QQ9N].

98. *Medina*, 606 U.S. at 365.

99. *Id.* at 378.

to enforcement exist if, such as in this case, the federal government agrees with a state shirking its duties.

By contrast, Justice Jackson's dissent emphasized the importance of being able to choose one's medical providers for patients. She emphasized the historical background of the statute, noting that Congress enacted the freedom-of-choice provision "in direct response to efforts by some jurisdictions to steer Medicaid beneficiaries to specific providers."[100] Jackson framed the right of Medicaid beneficiaries to "choose their own doctors" as an important federal right that is now thwarted by the Court's decision.[101]

Jackson is correct in that *Medina* opens the door to states excluding Planned Parenthood from their Medicaid programs, despite the fact that 32% of women and 11% of men have received healthcare services from a Planned Parenthood clinic.[102] Prior to *Medina*, at least fourteen states had either implemented state-level policies or sought permission from the federal government to implement policies excluding Planned Parenthood from participating in their Medicaid programs.[103] Beyond Planned Parenthood, *Medina* also opens the door to states becoming more selective about which providers can participate in their Medicaid programs for reasons beyond whether these providers can deliver acceptable quality healthcare services. This may force providers to acquiesce to state demands—even when those demands undermine the providers' independence and quality of care—in order to maintain their participation in Medicaid programs. In turn, *Medina* may also undermine patient trust in the medical profession. Patients may sense that physicians are constrained from offering appropriate or requested care because of their need to comply with state directives. Moreover, patients may feel that they are unable to choose providers who they trust, which may cause them to seek alternative pathways of care outside of the medical system.[104]

100. *Id.* at 409 (Jackson, J., dissenting).

101. *Id.* at 398 (Jackson, J., dissenting).

102. Brittni Frederiksen, Usha Ranji & Alina Salganicoff, *Major Federal and State Funding Cuts Facing Planned Parenthood*, KAISER FAM. FOUND. (May 15, 2025), https://www.kff.org/womens-health-policy/issue-brief/major-federal-and-state-funding-cuts-facing-planned-parenthood [https://perma.cc/7ZQQ-XEH4].

103. Sobel and Salganicoff, *supra* note 94.

104. For examples of this phenomenon, see generally REVERBY, *supra* note 49.

Medicaid's freedom-of-choice provision[105] is necessary for protecting medical providers from attacks on the basis of political or other nonmedical grounds. Without a strong freedom of choice provision, states may cut health service providers from Medicaid funding for political reasons, even when the providers meet the standards set forth by the medical profession. Thus, *Medina* significantly limits the ability of patients to insist on access to their preferred providers by removing their ability to pursue judicial remedies. Instead, *Medina* requires patients to rely on the federal government to ensure meaningful provider choice in Medicaid. Especially with a federal administration that is interested in slashing Medicaid spending rather than preserving the program, the lack of private enforcement could mean that patients are blocked from their providers of choice for a variety of reasons: cost, political ideology, or other services delivered by the provider. While *Medina* is a case about patient choices, it is also a case about whether providers will be forced to bend to the political whims of state Medicaid programs in order to reach their patients.

b. *United States v. Skrmetti*

In *United States v. Skrmetti*, the Supreme Court upheld Tennessee's Senate Bill 1 ("SB1"), a ban on gender-affirming care for patients under 18 years of age.[106] SB1 was passed in 2023. It bans the use of puberty blockers and hormone therapy for transgender minors on the basis that, as included in the text of the law, the state has a "legitimate, substantial, and compelling interest in encouraging minors to appreciate their sex, particularly as they undergo puberty."[107] The district court put the ban on hold in part because the treatments in question were safe, effective, and comparable in both risk profile and efficacy to many other forms of pediatric medicine that Tennessee permits.[108] The Sixth Circuit disagreed, however, and concluded that the ban could go into effect because it satisfied rational basis review.[109]

Chief Justice Roberts, writing for the Court, affirmed the Sixth Circuit's position and agreed that SB1 is not subject to heightened scrutiny.[110] The

105. 42 U.S.C. § 1396a(a)(23) (2024).

106. 605 U.S. 495, 525 (2025).

107. TENN. CODE ANN. § 68-33-101(m) (2024).

108. *Skrmetti*, 605 U.S. at 700-10.

109. L.W. v. Skrmetti, 83 F.4th 460, 486 (6th Cir. 2023), *aff'd sub nom.* United States v. Skrmetti, 605 U.S. 495 (2025).

110. *Skrmetti*, 605 U.S. at 509-25.

foremost legal question in *Skrmetti* was whether banning certain services to treat gender dysphoria in minors—but simultaneously allowing minors access to these treatments for other medical conditions—draws sex-based classifications and justifies a higher level of scrutiny. Critically, *Skrmetti* was also a case about when the state can ban access to medical treatments, even when those services have or may have real benefits and medical value.[111]

To conclude that Tennessee's ban does not draw classifications on the basis of sex, Roberts framed the law as focusing on "certain *medical uses*," not characteristics of the patients seeking care.[112] He also recognized the state's interest in protecting minors from physical and emotional harm and avoiding the risks of harm from these medical services.[113] In doing so, Roberts ignored the uncertainty around the harms the state alleged, treating the government's assertions as settled facts rather than contested arguments in an ongoing medical inquiry. He also did not engage with the problematic evidence and expertise introduced in *Skrmetti* and other

111. *See* Nicole Huberfeld & Michael R. Ulrich, United States v Skrmetti—*Testing the Transition to Politicized Regulation of Medicine*, 333 JAMA 839, 840 (2025) (arguing that *Skmretti* "could open the door further to state restrictions on health care for nonmedical reasons").

112. *Skrmetti*, 605 U.S. at 511.

113. *Id.* at 517-18.

related cases,[114] with "experts" testifying in favor of bans despite having never published or treated patients in this area.[115]

Roberts' approach to "medical uncertainty" and scientific evidence was foreshadowed in the *Skrmetti* oral arguments, in which Justice Alito cited the United Kingdom's *Cass Review*, an independent report commissioned by the United Kingdom's National Health Service which probed the quality of the supporting evidence for gender-affirming care and received widespread media coverage.[116] In doing so, Alito seems to have missed that the *Cass Review* does not call for a ban on gender-affirming care, but rather called for additional research and better data specific to puberty blockers in children and adolescents.[117] Likewise, Justice Kavanaugh, in oral arguments, seemed focused on whether medical uncertainty is enough to allow states to ban certain medical procedures.[118] The *Skrmetti* Court is one, like *Gonzales*, that sees "medical uncertainty" as an invitation for states to legislate, rather than

114. The challenge of incorporating scientific or medical evidence into judicial proceedings is not new, of course. Historically, courts have used the *Frye* test, i.e., whether the expert testimony was sufficiently established to have gained general acceptance in the particular field in which it belongs. Frye v. United States, 293 F. 1013 (D.C. Cir. 1923). In 1993, the Supreme Court shifted this approach to a four-factor test for the trial judge to consider, including: (1) if the theory has been tested; (2) if the theory has been subjected to peer review or publication; (3) the known rate of error and any applicable standards; and (4) whether the scientific community has generally accepted the theory in question. Daubert v. Merrell Dow Pharms., Inc., 509 U.S. 579, 590-94 (1993). The newer *Daubert* approach takes the gatekeeping role from the scientific community and bestows it upon the judge. The centrality of the judge as gatekeeper was later upheld in *General Electric Co. v. Joiner*, which reaffirmed that trial courts have wide discretion to exclude expert scientific testimony. 522 U.S. 136 (1997). *Daubert* has been criticized by those in the medical profession as assuming that all judges are capable of evaluating the quality of expert testimony according to these four factors, when they may lack the training to do so. *See* Robert Brent, *The Daubert Decision*, 5 PEDIATRICS 2222, 2223 (2006).

115. Huberfeld & Ulrich, *supra* note 111, at 840.

116. Transcript of Oral Argument at 15-16, United States v. Skrmetti, 605 U.S. 495 (2025) (No. 23-477) [hereinafter *Skrmetti* Oral Argument].

117. Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report*, NAT'L HEALTH SERV. ENG. (2024), https://cass.independent-review.uk/home/publications/final-report [https://perma.cc/ATF6-M7A6].

118. *Skrmetti* Oral Argument at 142.

as a suggestion that the medical profession be allowed to further research and refine its practices.

Justice Thomas, in his concurrence, went further to undermine the practice of medicine, referring to researchers and clinicians involved in this case on the side of the plaintiffs as "self-described experts" and decrying the "elite sentiment to distort and stifle democratic debate under the guise of scientific judgment."[119] Thomas concluded that these physicians and scientists use "their medical recommendations to achieve political ends."[120] He approvingly noted that the Court correctly reserves to "'the people, their elected representatives, and the democratic process' the power to decide how best to address an area of medical uncertainty and extraordinary importance" in a way that "does not bow to 'major medical organizations.'"[121] If Justices Roberts, Alito, and Kavanaugh are comfortable allowing states to cut off medical research before there can be a fuller understanding of an issue, Justice Thomas seems happy to allow states to entirely disregard best medical practices because of his deep suspicion of the profession overall.

Ultimately, *Skrmetti* clearly speaks to the Supreme Court's misunderstanding of medical uncertainty as an invitation for state action. *Skrmetti* also highlights the challenges of explaining to legal and political actors how the scientific method and evolving medical practices can competently address medical uncertainty. As a result, *Skrmetti* creates a legal landscape in which, as Sara Rosenbaum writes, "legislatures have extremely broad powers over health care regulation," and the Court's decision "does not appear to have a clear stopping point."[122] As Nicole Huberfeld and Michael R. Ulrich have noted, *Skrmetti* implicates "not only constitutional protection against government discrimination, but also state regulation of the practice of medicine more broadly."[123] This is because the *Skrmetti* Court both broadly conceded the states' ability to ban medical procedures, so long as the Court finds no impermissible discrimination, and gave significant benefit of the doubt to Tennessee that it provided evidence

119. United States v. Skrmetti, 605 U.S. 495, 531 (2025) (Thomas, J., concurring).

120. *Id.* at 547 (Thomas, J., concurring).

121. *Id.*

122. Sara Rosenbaum, *Supreme Court Upholds Ban on Gender-Affirming Care for Minors: The Meaning of* US v Skrmetti, HEALTH AFFS. FOREFRONT (June 25, 2025), https://www.healthaffairs.org/do/10.1377/forefront.20250624.854317/full [https://perma.cc/XP2G-YN5P].

123. Huberfeld & Ulrich, *supra* note 111, at 839.

to demonstrate a rational connection between its policy goals and its actions.[124]

Much of the justification the Court used in *Skrmetti* was tied to its understanding that medical uncertainty existed as to the best course of treatment for minors with gender dysphoria and its unwillingness to allow the medical profession to resolve that uncertainty using its own methods. In doing so, *Skrmetti* tips the balance of power between physicians as regulators of medical practice and states as regulators of health and general welfare, allowing the states to overreach into the area historically governed by the medical profession. It also further undermines the relationship between physicians and patients—and thus erodes trust—because patients will experience denials of care from their providers based on what physicians must do to comply with the state rather than what they believe is best for their patients.

c. *Kennedy v. Braidwood Management, Inc.*

The last healthcare-focused case of the October 2024 term, *Kennedy v. Braidwood Management, Inc.*, further reinforces the encroachment on the medical profession. If *Skrmetti* emphasizes that the state can disregard the medical profession's assessment of a particular treatment, *Braidwood* does the same for the relationship between the administrative state and the medical profession. In doing so, it undermines the independence of scientific expert advisory committees, which in turn undermines the value of federal recommendations and guidelines.

At the heart of *Braidwood* is a challenge to the Affordable Care Act's (the "ACA") no-cost preventive-care mandate, which required insurers to cover, without copayments or coinsurance requirements, the services recommended by the United States Preventive Services Task Force (the "USPSTF").[125] As discussed in further detail below, the USPSTF is one of

124. *See* Michael R. Ulrich, *Politicians as Clinicians:* Skrmetti *and Supreme Court–Sanctioned Intrusion on the Practice of Medicine*, 10 JAMA 855, 855 (2025) (arguing that the Court "twists and contorts the statute and its own jurisprudence in an effort to shroud targeted discrimination as a simple matter of state action regulating the practice of medicine" and cautioning that in doing so, the Court indicates that it "is willing to uncritically accept state claims of protection; and that experience and expertise have little to do with legal analysis, even when it comes to medicine, science, and public health").

125. Andrew J. Twinamatsiko & Lawrence O. Gostin, *Curbing Agency Expertise Threatens Public Health:* Braidwood *and the Nondelegation Doctrine*, 50 AM. J.L. & MED. 24, 25 (2024).

many expert advisory committees that has been used to help federal administrative agencies incorporate scientific and medical evidence into regulation.

The USPSTF began in 1984 as a purely advisory scientific body, issuing evidence-based recommendations about clinical preventive services.[126] Its work gained importance when the ACA created a mandate for insurers to cover all services it recommended at an A or B level with no cost sharing imposed on enrollees. In doing so, the ACA amended the USPSTF's governing statute to require that members and their recommendations "be independent and, to the extent practicable, not subject to political pressure."[127] The no-cost preventive-care mandate is important because even nominal fees reduce uptake of preventive services.[128] The independence of the USPSTF is perhaps even more important because it is the body that directs which preventive services should be considered the standard of care and easily accessible.

Initially, *Braidwood* was a Religious Freedom Restoration Act case, with the plaintiffs alleging, and the district court agreeing, that forcing them to facilitate access to HIV Pre-exposure Prophylaxis ("PrEP") and other services violated their sincerely held religious beliefs.[129] However, the district court also held that the selection process for USPSTF members violated the Constitution's Appointments Clause. The Appointments Clause requires that all principal officers of the United States be nominated by the President and confirmed by the Senate, which was not the case for the independent volunteers who comprised the USPSTF membership.[130] The

126. NAT'L ACADS. OF SCIS., ENG'G & MED., *Clinical Practice Guidelines and the U.S. Preventive Services Task Force*, *in* CLOSING EVIDENCE GAPS IN CLINICAL PREVENTION 25, 28 (Alexis Wojtowicz, Kathleen Stratton, & Tracy A. Lieu eds., 2021).

127. 42 U.S.C. §§ 299b-4(a)(1), (6) (2024).

128. *See* Elizabeth Kaplan & Anu Dairkee, *The Broken Link:* Braidwood*, the United States Preventive Services Task Force (USPSTF), and the Health Equity Implications of Losing Free Access to Preventive Care*, 50 AM. J.L. & MED. 100, 102 (2024). *See generally* A. David Paltiel et al., *Increased HIV Transmissions with Reduced Insurance Coverage for HIV Preexposure Prophylaxis: Potential Consequences of* Braidwood Management v. Becerra, OPEN F. INFECTIOUS DISEASES, Mar. 2023, at 1 (detailing how *Braidwood* will undermine ongoing efforts to reduce disparities in cancer and HIV).

129. Braidwood Mgmt. v. Becerra, 627 F. Supp. 3d 624, 652 (N.D. Tex. 2022), *aff'd in part, rev'd in part, and remanded*, 104 F.4th 930 (5th Cir. 2024), *rev'd and remanded sub. nom.* Kennedy v. Braidwood Mgmt., 606 U.S. 748 (2025).

130. *Id.* at 646.

Fifth Circuit agreed that the USPSTF members exercised substantial independent authority and had no overseeing official to approve or deny their recommendations and, therefore, were principal officers who needed to be appointed by the President.[131] By shifting the focus of the case to the Appointments Clause, *Braidwood* became a case about whether expert advisory committees can maintain independence from their host administrative agency and, therefore, preserve their scientific integrity.

The Supreme Court found that USPSTF members are inferior officers, which in turn raises questions about how the USPSTF and other expert advisory committees can maintain significant independence from agency leadership sufficient to preserve scientific integrity. Writing for the majority, Kavanaugh concluded that USPSTF members are inferior officers because the Secretary of Health and Human Services has significant power to supervise and direct their work.[132] Notably, the Secretary has the power to decide whether to adopt each USPSTF recommendation. The Court rooted this power in statutory texts that give the HHS Secretary general supervisory authority over the USPSTF, including the ability to enact regulations governing the body.[133] Furthermore, the Secretary has the power to remove members at will and replace them with appointees more to his or her liking.[134] Kavanaugh's conclusions that the USPSTF is not particularly insulated from the Secretary's influence appear to conflict with statutory language requiring the USPSTF to be "independent and, to the extent practicable, not subject to political pressure."[135] Kavanaugh instead interpreted this language to mean that the USPSTF should be free of undue influence from outside affiliations and conflicts of interest, but not insulated from the Secretary and HHS leadership.[136]

Braidwood is a positive for public health in that it maintains the preventive-care mandate and the USPSTF.[137] Before the Supreme Court's decision, scholars were worried that *Braidwood* would join the recent line of cases "increasing judicial rejection of agency actions that expand the

131. Braidwood Mgmt. v. Becerra, 104 F.4th 930, 946 (5th Cir. 2024),), *rev'd and remanded sub. nom.* Kennedy v. Braidwood Mgmt., 606 U.S. 748 (2025).

132. *Braidwood*, 606 U.S. 748, 762 (2025).

133. *Id.* at 767.

134. *Id.* at 764.

135. 42 U.S.C. § 299b-4 (2024).

136. *Braidwood*, 606 U.S. at 773.

137. Carmel Shachar & Elizabeth Kaplan, *Preventive Care Coverage Threatened by Federal Court Ruling*, 332 JAMA 1605, 1605 (2024).

federal regulatory presence in health policy."[138] *Braidwood*, however, will come to stand for another proposition: the ability of HHS and political leadership to undermine independent, expert advisory committees. To avoid being deemed principal officers, members of expert advisory committees must be subordinate to HHS political leadership.

Braidwood comes at a time when there is significant upheaval at HHS and a Secretary whose views are often unorthodox and contradict medical consensus, especially on vaccines.[139] *Braidwood* gives permission to the Secretary to continue to ride roughshod over expert advisory committees, as discussed further below. It also will contribute to growing distrust between patients and providers as government-issued recommendations can increasingly conflict with guidance from medical societies and organizations.

Medina, *Skrmetti*, and *Braidwood* all limit the independence and freedom of medical decision-makers, often using medical uncertainty as a justification for doing so. If Medicaid patients are not at liberty to choose a qualified provider, physicians will have to bend to the political demands of state Medicaid programs to treat their patients. If there is medical uncertainty—a normal situation in a field in which we are continually revising our knowledge and understanding—states are justified in banning access to services. Now that the Court has undermined the independence of expert advisory committees, it is harder for them to maintain the integrity of their recommendations in the face of administrative agency pressures.

2. State Court Encroachment on the Medical Profession

State courts are also limiting medical independence, in part by interpreting legislation in ways that prevent medical professionals from making their own determinations of medical necessity. Although this Section will focus on the regulation of abortion as a lens for understanding state court encroachment, state courts frequently handle a variety of public

138. Michelle M. Mello & Anne Joseph O'Connell, *The Fresh Assault on Insurance Coverage Mandates*, 388 NEW ENG. J. MED. 1, 2 (2023); *see also* Abbe R. Gluck, *Situating* Braidwood *in Broader Conversations about Health Policy and Administrative Law*, 50 AM. J.L. & MED. 1, 9 (2024) (discussing the Court's new "attack on [agency] expertise" in major recent healthcare deference cases).

139. Arthur Allen & Sam Whitehead, *Kennedy's Vaccine Advisers Sow Doubts as Scientists Protest US Pivot on Shots*, KAISER FAM. FOUND. HEALTH NEWS (June 27, 2025), https://kffhealthnews.org/news/article/kennedy-rfk-vaccine-panel-acip-cdc-hhs-immunizations [https://perma.cc/9JYC-5566].

health or health-law cases. As discussed above, states are often appropriately tasked with regulating to promote public health and welfare through their "police powers."[140] In recent years, however, states have become more aggressive about regulating certain medical services, such as abortion care, gender-affirming care, and access to vaccines.[141] Consequently, state courts frequently articulate their views on the appropriate degree of self-regulation for the medical profession.

The trend of encroachment is very visible when it comes to access to abortion care. There is a significant amount of litigation around abortion bans and shield laws protecting abortion providers. Some of this litigation has focused on the exceptions to abortion bans, often to preserve the life and health of the pregnant patient.[142] For example, Texas is a state with a near ban on abortion, with an exception for when the patient "has a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function."[143] This language, like the language in many other states' life and health exceptions, is not particularly helpful guidance for patients and providers who may face time-sensitive and high-stakes decisions. And decisions about abortion to avoid anticipated and possibly severe complications of pregnancy are equally high-stakes, but are all but precluded by this language. Moreover, "substantial" is a term used frequently in law, including in abortion bans, but it has no medical meaning.[144]

ACOG explains the tension between legal requirements and medical judgment, noting that "[w]hile clinicians know how to provide evidence-based and lifesaving care for their patients based on years of training and experience, it is impossible for a law to appropriately capture how or whether a 'medical emergency' exception applies to a particular clinical

140. Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201, 201-02 (1999).

141. Katherine Florey, *The New Landscape of State Extraterritoriality*, 102 TEX. L. REV. 1135, 1145-48 (2023).

142. Carmel Shachar, Susannah Baruch & Louise P. King, *Whose Responsibility Is It to Define Exceptions in Abortion Bans?*, 331 JAMA 559, 559-60 (2024).

143. TEX. HEALTH & SAFETY CODE ANN. § 170A.002(b)(2) (West 2025).

144. Melissa Morgan, *Medical Judgment and Maternal Health Exceptions in the New Era of Abortion Criminalization*, 30 TEX. J. C.L. & C.R. 1, 14 (2024).

situation."[145] There are high stakes for the physician in interpreting whether the legal exception allows for an abortion: If they provide services when the exception does not apply, they run the risk of ruinous fines and carceral time. If physicians withhold necessary services, their patients could experience significant harm or even death. It is unsurprising that, post-*Dobbs*, in a 2023 survey, half of obstetricians and gynecologists ("OB/GYNs") practicing in abortion-restrictive states were worried about their legal risks in making medical decisions.[146] In the same survey, 36% of OB/GYNs surveyed nationally felt that their ability to practice to the standard of care had been undermined; that number rose to 55% in states where abortion is banned.[147]

It is amidst this medical-legal conflict that the Texas Supreme Court weighed in on the balance of decision-making power between physicians and the state in *State v. Zurawski*.[148] Twenty-two Texan women were denied abortions despite experiencing severe complications, fatal fetal abnormalities, and life-threatening emergencies. They sued in 2023 to clarify the scope of Texas's medical exception to its abortion bans. Their core position was that "where an abortion ban provides an exception for patients in certain circumstances, a good faith standard, rather than a reasonable person standard, must apply."[149]

The stage for *Zurawski* had been set by an earlier case, *In re State*.[150] In that case, the Texas Supreme Court ruled against Kate Cox, who was seeking

145. *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Aug. 15, 2022), https://www.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptions-in-abortion-bans-restrictions [https://perma.cc/27JP-7JL2].

146. Brittni Frederiksen, Usha Ranji, Ivette Gomez & Alina Salganicoff, *A National Survey of OBGYNs' Experiences After Dobbs*, KAISER FAM. FOUND. 12 (June 2023), https://files.kff.org/attachment/Report-A-National-Survey-of-OBGYNs-Experiences-After-Dobbs.pdf [https://perma.cc/WQ4H-T5H9].

147. *Id.* at 12-13.

148. State v. Zurawski, 690 S.W.3d 644 (Tex. 2024); *Seeking Clarity on Emergency Exceptions to Texas's Abortion Bans*, CTR. FOR REPROD. RTS. (Jan. 5, 2026), https://reproductiverights.org/cases/zurawski-v-state-texas [https://perma.cc/9G6A-4AQF].

149. Plaintiffs' First Amended Verified Petition for Declaratory Judgment & Application for Temporary & Permanent Injunction at 67, Zurawski v. State, No. D-1-GN-23-000968 (Dist. Ct. Travis Cnty. May 22, 2023).

150. 682 S.W.3d 890 (Tex. 2023).

an abortion, and emphasized that the legislature required doctors to meet an objective standard of "reasonable medical judgment," rather than a "good faith standard."[151] The court argued, without citing any precedent, that the good faith standard was a "lower standard" than the reasonable-medical-judgment standard.[152] In doing so, the court created a tension within its own decision because it continually argued that "courts cannot go further by entering into the medical-judgment arena" and that the opinion does not "prevent[] a physician from acting if, in that physician's reasonable medical judgment, she determines that [the patient] has a 'life-threatening physical condition' that places her 'at risk of death' or 'poses a serious risk of substantial impairment . . . unless the abortion is performed.'"[153] As Melissa Morgan argues, however, the imposition of "reasonable medical judgment" requires some sort of adjudication to see if a physician's actions match an external standard, which requires the courts (or another adjudicative actor) to evaluate the actions of the physician and also for the physician to be forced to act without any guarantees that their determination will have met the necessary criteria, potentially chilling their willingness to act.[154]

The central question of *Zurawski* was whether the Texas Supreme Court would support the medical profession's ability to determine the scope of its practice within the context of the abortion ban. A good faith standard for using the medical exception to an abortion ban would allow physicians to utilize this exception when they believe it to be medically necessary and would not require physicians to prove that their judgment was objectively reasonable. A reasonable person standard, on the other hand, potentially allows government political actors such as state legislators or prosecutors to punish physicians for the care they have provided in good faith, by substituting the state actor's own nonexpert judgment for the physician's decision-making. The result is "war of the experts" litigation: The prosecuting side finds experts willing to testify that the care was not what a reasonable person would have provided and the abortion was not medically necessary.[155] Thus, the reasonable person standard creates a significant chilling effect on physicians, who are afraid of the consequences should their decisions be challenged successfully.

151. *Id.* at 894.

152. *Id*.

153. *Id.* at 894-95.

154. Morgan, *supra* note 144, at 16-23.

155. *Id.*

However, the good faith standard still permits challenges to the physician's decision-making. Physicians making decisions in good faith are still accountable to standards set by their profession, whether these standards are established through state medical boards, hospitals' granting of privileges, patients' complaints to national specialty boards, or medical malpractice lawsuits holding physicians to the standard of care expected of a similarly skilled healthcare professional. What is different about the "reasonable person" standard is that it introduces a danger that the physician's "reasonable medical judgment" will be judged through the perspective of a nonexpert political actor. The physician risks being embroiled in life-altering litigation and prosecutions.[156]

Unfortunately, the *Zurawski* court agreed that the reasonable person standard, not the good faith standard, was correct. Despite its protestations that the decision-making power is within the hands of the physician, the court ultimately failed to clarify the scope of the medical exception to its abortion ban, leaving both physicians and patients vulnerable, potentially, to the whims of prosecutors, judges, and juries.[157]

In Kate Cox's case, the Texas Supreme Court suggested that the Texas Medical Board provide additional guidance.[158] The Texas Medical Board is arguably an apparatus of the state, in contrast with the medical societies which set best practices. The court defined the Texas Medical Board as an "executive branch entit[y]" and not as a vehicle for medical self-determination, and noted that the Board should provide guidance to clarify the reasonable person standard.[159] The court then further emphasized that the decision-making power should be within the state and not the medical profession by suggesting that "if the Board does provide guidance, it can request an opinion from the Attorney General, who has substantial civil-enforcement authority, regarding the legal effect of physicians' compliance with the Board's guidance."[160] The Texas Medical Board, which does not

156. *Id.*

157. *See generally* Susannah Baruch, Louise P. King & Carmel Shachar, *Intrusion in the Practice of Medicine*, 333 JAMA 1389, 1389 (2025) (evaluating Texas's proposals to define the scope of the life exception for the state's abortion ban and arguing that these approaches do not allow physicians to follow the national standards of care, avoid criminal liability, or have sufficient notice of what the law permits).

158. *In re* State, 682 S.W.3d at 895.

159. *Id*.

160. *Id.* at 894 n.5.

have an OB/GYN member at the time of writing, later released guidance. But this guidance failed to provide clarity to physicians practicing in Texas.[161]

Both the *Zurawski* decision and Kate Cox's case are examples of courts disregarding the medical profession's expertise in determining what care should be offered to patients, instead relying on legal standards and government actors to delineate available care.

C. Executive and Administrative Encroachment

The current Administration has been particularly focused on undermining both scientific and medical expertise in its encroachment on the medical profession. It seeks to collapse the space between policy expertise and medical expertise and to exert political control over medical expertise. The protracted battle between the Administration and expert advisory committees has dissolved bodies of experts or subsumed them under political entities.

1. Administrative Encroachment on Expert Advisory Committees

In general, administrative law has framed federal rulemaking as more about expertise than politics.[162] Congress often gave federal agencies the power to convene expert advisory groups or established them outright through legislation to furnish expertise unlikely to be found within the administrative agencies themselves.[163] Much of the process governing these groups, which include advisory groups throughout HHS including at the U.S. Centers for Disease Control and Prevention (the "CDC") and the U.S. Food and Drug Administration (the "FDA"), comes from the Federal Advisory

161. *See* Neelam Bohra, *Texas Medical Board Proposes New Guidance for Abortion Medical Exceptions*, TEX. TRIB. (Mar. 22, 2024), https://www.texastribune.org/2024/03/22/texas-medical-exception-board-abortion-guidance [https://perma.cc/3529-AD7H] (quoting several physicians as saying that the new guidance was not sufficient to provide guidance to physicians).

162. Peter L. Strauss, *From Expertise to Politics: The Transformation of American Rulemaking Speech*, 31 WAKE FOREST L. REV. 745, 753 (1996) ("The dominant understanding was that agency action was 'expert,' intended to operate at some remove from politics.").

163. FRANCIS E. ROURKE, BUREAUCRACY, POLITICS, AND PUBLIC POLICY 123 (2d ed. 1976).

Committee Act of 1972.[164] In the past, expert advisory committees and the convening agency have disagreed, as was the case with the FDA's controversial approval of Aduhelm to treat Alzheimer's against a nearly unanimous negative advisory committee vote.[165] But in general, agencies have benefited reputationally from engaging these committees,[166] and tend to follow the relevant committee's recommendations.[167]

Recently, however, HHS leadership has opened a significant rift with many of the expert advisory committees. In March 2025, the Administration terminated the CDC's Healthcare Infection Control Practices Advisory Committee, which provides recommendations on evidence-based practices to reduce healthcare-associated infections.[168] Other committees such as the USPSTF survive but with greatly diminished independence and, thus, undermined integrity. *Braidwood*, as discussed above, strengthens administrative agency control over expert advisory committees by allowing the Secretary of HHS significant control over the USPSTF—to avoid finding USPSTF members principal officers whose selection must comply with the Appointments Clause. Over the summer of 2025, the American Medical Association and other health organizations[169] responded with alarm to media reports that Secretary Robert F. Kennedy Jr. was planning to fire all

164. Federal Advisory Committee Act of 1972 § 10, Pub. L. No. 92-463, 86 Stat. 770, 774 (1972) (codified at 5 U.S.C. § 1009).

165. C. Joseph Ross Daval, Ameet Sarpatwari & Aaron S. Kesselheim, *Unwanted Advice? Frequency, Characteristics, and Outcomes of Negative Advisory Committee Votes for FDA-Approved Drugs*, 41 HEALTH AFFS. 713, 714 (2022).

166. Susan L. Moffitt, *Promoting Agency Reputation Through Public Advice: Advisory Committee Use in the FDA*, 72 J. POL. 880, 891 (2010).

167. Daval et al., *supra* note 165, at 713.

168. Thomas R. Talbot, Michael Yen-Wei Lin, Deborah S. Yokoe & Lisa L. Maragakis, *Termination of a Federal Infection Prevention Advisory Committee: Eroding Health Care Safety*, 334 JAMA 389, 389 (2025).

169. Kevin B. O'Reilly, *Hands off the U.S. Preventive Services Task Force, Says AMA*, AMA (July 28, 2025), https://www.ama-assn.org/health-care-advocacy/federal-advocacy/hands-us-preventive-services-task-force-says-ama [https://perma.cc/NN2Q-278R]; Ahmed Aboulenein & Deena Beasley, *Kennedy to Oust Care Task Force, WSJ Reports; HHS Says No Decision Yet*, REUTERS (July 25, 2025), https://www.reuters.com/business/healthcare-pharmaceuticals/kennedy-oust-care-task-force-wsj-reports-hhs-says-no-decision-yet-2025-07-25 [https://perma.cc/U2WP-VBYL].

members of the USPSTF[170] and replace qualified members with less expert, more partisan appointees, which in turn would undermine the preventive-care recommendations issued by this group.

The concern about USPSTF is grounded in the experience of other expert advisory committees.[171] Secretary Kennedy fired all the existing members of the Advisory Committee on Immunization Practices ("ACIP") and replaced them with appointees who often had little experience in the field or are actively hostile to vaccines.[172] The move was so controversial that the American Academy of Pediatrics, which customarily sent a representative to ACIP meetings, declined to send a participant and noted that it would issue its own recommendations.[173] Indeed, in the first meeting, the newly reconstituted and controversial ACIP voted to pull certain flu vaccines off the market for containing thimerosal, despite the medical consensus and evidence that these vaccines are safe and appropriate.[174] In subsequent meetings, ACIP voted to end routine hepatitis B immunizations for newborns,[175] a rollback that epidemiologists are concerned will lead to

170. Richard Hughes IV & Carmel Shachar, Braidwood*'s Double-Edged Sword and the Dismantling of Preventive Care*, HEALTH AFFS. FOREFRONT (Aug. 28, 2025), https://www.healthaffairs.org/do/10.1377/forefront.20250825.888071/full [https://perma.cc/S4GH-PDFG].

171. *See generally* Gregory Curfman, Marcia Boumil & Kirsten Bibbins-Domingo, *Insurance Coverage Without Cost Sharing for Preventive Health Care Restored by the Supreme Court*, 334 JAMA 573 (2025) (critically examining the implications of *Braidwood* for preventive healthcare in the United States).

172. Richard Hughes & Sara Rosenbaum, *Vaccine Policy in Crisis: Secretary Kennedy Dismisses Entire Advisory Committee on Immunization Practices*, HEALTH AFFS. FOREFRONT (June 11, 2025), http://www.healthaffairs.org/do/10.1377/forefront.20250610.593269/full [https://perma.cc/WC6J-HY8Z]; Chelsea Cirruzzo, *Vaccine Advisers to Consider MMRV Vaccines, "Thimerosal Containing" Flu Shots in Pared-Down Meeting*, STAT NEWS (June 18, 2025), https://www.statnews.com/2025/06/18/rfk-jr-acip-vaccine-advisers-flu-shots-thimerosal-mmrv-covid-rsv [https://perma.cc/C6JX-U4TJ].

173. Allen & Whitehead, *supra* note 139.

174. Helen Branswell, *CDC Advisory Panel, Selected by RFK Jr., Recommends Thimerosal Be Dropped from Flu Vaccines*, STAT NEWS (June 26, 2025), https://www.statnews.com/2025/06/26/rfk-jr-new-acip-panel-bans-thimerosal-in-flu-shots-preservative-long-a-target-of-antivax-activists [https://perma.cc/2VJ6-W84M].

175. Pien Huang, *CDC Advisers Vote to Overturn Decades-Long Policy on Hepatitis B Vaccine for Infants*, NPR (Dec. 5, 2025), https://www.npr.org/sections/shots-

a spike in hepatitis B and lifelong impacts for infected infants.[176] These actions come at the heels of HHS leadership bypassing ACIP to issue changes to COVID-19 vaccine policy directly on social media.[177] This included the Secretary of HHS announcing on the social media website X that the COVID-19 vaccine for healthy children and pregnant people would be removed from the recommended immunization schedule, which in turn undermined public confidence in the vaccine and created barriers to access and reimbursement for those who still wanted to be vaccinated.[178] This created chaos and confusion for patients, providers, and insurers, with concerns that individuals would not be able to access vaccines recommended by medical guidelines.

2. Administrative Encroachment Using Conditions of Participation to Control Medical Practice

Another act of encroachment by the current Administration upon the medical profession is its use of Medicare and Medicaid conditions of participation to limit the scope of practice. Early in the second Trump Administration, an executive order entitled "Protecting Children from Chemical and Surgical Mutilation" required HHS to modify the Medicare and Medicaid funding conditions to exclude any healthcare organization providing gender-affirming care, even if this care is not supported by

health-news/2025/12/05/nx-s1-5634004/cdc-hepatitis-b-vaccine-acip-meeting [https://perma.cc/LK79-BZNH].

176. *See generally* Michael S. Abers, Angela K. Ulrich & Rochelle P. Walensky, *Universal Hepatitis B Vaccination at Birth—Risks of Revising the Recommendation*, 335 JAMA 569 (2025) (providing a viewpoint from infectious disease experts cautioning about the consequences of rescinding the ACIP policy to immunize all newborns against hepatitis B.).

177. Edwin J. Asturias et al., *Advisory Committee on Immunization Practices at a Crossroads*, 334 JAMA 667, 668 (2025).

178. *RFK Jr. Says Covid-19 Shot Will No Longer Be Recommended for Healthy Children and Pregnant Women*, CNN (May 27, 2025), https://www.cnn.com/2025/05/27/health/covid-vaccine-pregnant-women-children-recommendation [https://perma.cc/CW9E-E6Y6]; *see also* Jess Steier, David Higgins, Elana Pearl Ben-Joseph & Aimee Pugh Bernard, *Policy by Tweet: How RFK Jr. Broke 60 Years of Vaccine Decision-Making Process*, UNBIASED SCI. (May 28, 2025), https://theunbiasedscipod.substack.com/p/policy-by-tweet-how-rfk-jr-broke [https://perma.cc/WE7M-WNH4] (explaining the potential impact); Asturias et al., *supra* note 177.

federal funds.[179] At the time of writing, HHS is implementing this executive order through rulemaking.[180] This approach, using Medicare and Medicaid funding as a tool to prevent physicians from providing medically necessary services, even if those services are funded privately, represents a significant increase in governmental control over the scope of practice and directly contradicts the founding statutory language of Medicare and Medicaid.[181]

Medicare and Medicaid were established by the Social Security Act. The Act granted the HHS Secretary broad powers to administer both programs. The Act, as discussed above, explicitly prohibited the Secretary from using these powers to interfere in the practice of medicine, noting that "[n]othing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided."[182] As Wilbur Cohen, one of the primary architects of these programs, later reflected, this provision was important to appease the American Medical Association and other physicians who had strong concerns about the impact that a federally funded health insurance program would have on the diagnosis and treatment of patients.[183]

Consequently, until recently, HHS could use funding conditions to enact requirements that protect the health and safety of patients, but could not use funding conditions to direct clinical judgment.[184] Examples of appropriate regulations designed to address health and safety include requiring training of hospital personnel and staff on infection prevention

179. Exec. Order No. 14,187, 90 Fed. Reg. 8771 (Feb. 3, 2025).

180. Medicare and Medicaid Programs; Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children, 90 Fed. Reg. 59463 (proposed Dec. 19, 2025) (to be codified at 42 C.F.R § 482).

181. Carmel Shachar, Julia Lynch & Kevin Costello, *Federal Funding Conditions Threaten Gender-Affirming Care Access and Physician Autonomy*, 334 JAMA 1137, 1138 (2025).

182. Medicare and Medicaid Act, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified at 42 U.S.C. § 1395).

183. Cohen, *supra* note 77, at 8. It is true that, at times, the medical profession has engaged in lobbying and other attempts to influence the political process. We believe, however, that medical engagement with the political process does not constitute encroachment because the medical profession is not attempting to usurp the functions and powers of state actors. Instead, the profession is acting as a constituent, albeit a well-educated, well-connected, and influential one.

184. Shachar et al., *supra* note 181, at 1137.

and control guidelines,[185] requiring qualified dieticians to have completed at least 900 hours of supervised practice,[186] setting how long an admitted or surgical patient can wait before they must be examined,[187] and outlining protocols for the procurement, transportation, and transplantation of human organs.[188] While all of these regulations shaped *how* services could be offered to patients, none of these regulations dictated *what* services a physician could provide.[189]

By tying Medicare and Medicaid funding to the provision of gender-affirming care services, the current Administration is directly in conflict with congressional intent as articulated in the Social Security Act, which sought to protect the medical profession from the control of federal officers.[190] It also violates the longstanding convention that HHS does not control the scope of practice for physicians through its purse. Should the Administration use funding conditions as a tool to successfully restrict physicians from offering gender-affirming care, it would pioneer an unprecedented ability to control what services physicians can offer *any* patients, not just those in government payor programs. But these trends toward encroachment are not unique to the Trump Administration. They are also increasingly prevalent across the states.

185. Condition of Participation: Infection Prevention and Control and Antibiotic Stewardship Programs, 42 C.F.R. § 482.42 (2025).

186. Food and Nutrition Services, 42 C.F.R. § 483.60.

187. Condition of Participation: Medical staff, 42 C.F.R. § 482.22.

188. Condition of Participation: Organ, Tissue, and Eye Procurement, 42 C.F.R. § 482.45.

189. Congress, of course, can attach funding conditions to federal funding under the Spending Clause. But administrative agencies cannot impose funding conditions beyond what Congress has authorized. In this case, Congress has explicitly prohibited HHS from using funding conditions to control the practice of medicine. *See supra* note 76 and accompanying text. For more discussion of the federalism issues, see Nicole Huberfeld & Carmel Shachar, *Proposed HHS Rule on Gender-Affirming Care Radically Expands Use of Medicare, Medicaid as Policy Weapons*, STAT NEWS (Dec. 24, 2025), https://www.statnews.com/2025/12/24/gender-affirming-care-hhs-rule-medicare-medicaid-weapons [https://perma.cc/VJ7E-QMSA].

190. *Id.*; *see also supra* notes 74-77 and accompanying text.

3. State Administrative and Legislative Encroachment on Medical Decision-Making

State administrative and legislative leaders are also diminishing the medical profession's ability to regulate itself and the ability of physicians and patients to engage in medical decision-making. States are traditionally granted police power to promote the health and welfare of their citizens,[191] making it more difficult to distinguish appropriate state regulation from state encroachment on the medical profession than it is in the federal context. State departments of public health, for example, are considered a normal and appropriate expression of state action in healthcare. These agencies articulate health policies, including vaccine and quarantine policies during pandemics.[192] When these actions are not guided by evidence-based practices and guidelines or are not motivated by improving health or promoting safety, they become harmful forms of state encroachment.

For example, states have encroached on medical self-regulation by passing laws around the treatment of pregnant patients who need end-of-life care.[193] Adriana Smith's recent case in Georgia (while complex and likely simplified in its public reporting) is illustrative of the confusion and challenges that occur in these circumstances. Ms. Smith went to the hospital due to headaches. Her care team discovered she had blood clots in her brain. She was declared brain-dead but was nine weeks pregnant at that time.[194]

Ms. Smith's family reported that her medical team told them that Georgia law required them to keep Smith on life support until her fetus reached viability.[195] Namely, Georgia's H.B. 481, the "Living Infants Fairness

191. *See supra* note 72 and accompanying text.

192. *See State & Local Public Health: An Overview of Regulatory Authority*, PUB. HEALTH L. CTR., https://www.publichealthlawcenter.org/resources/state-local-public-health-overview-regulatory-authority [https://perma.cc/3F8D-G72L].

193. *See generally* Erin S. DeMartino et al., *US State Regulation of Decisions for Pregnant Women Without Decisional Capacity*, 321 JAMA 1629 (2019).

194. Janice Hopkins Tanne, *US Abortion Restrictions Are Keeping Brain Dead Pregnant Woman on Life Support*, BRIT. MED. J. (May 30, 2025), https://www.bmj.com/content/389/bmj.r1120.

195. Jess Mador, *Does Georgia's Fetal 'Personhood' Law Mean a Pregnant Woman Must Stay on Life Support?*, NPR (June 7, 2025), https://www.npr.org/sections/shots-health-news/2025/06/07/nx-s1-

and Equality (LIFE) Act" forbids an abortion after fetal cardiac activity, which generally occurs around six weeks.[196] The Georgia Attorney General's Office asserted that removing life support after brain death would not be "an action with the purpose of terminating a pregnancy" and therefore, not an abortion under H.B. 481.[197] However, a Georgia state senator who authored H.B. 481 went on record supporting the hospital's decision to keep Ms. Smith on life support: "I think it is completely appropriate that the hospital do what they can to save the life of the child . . . . I think this is an unusual circumstance, but I think it highlights the value of innocent human life."[198] While the state senator did not expressly state that H.B. 481 mandated this outcome, the discrepancies between the attorney general and the state senator speak to an important and alarming aspect of encroachment: that the interpreters of what care is appropriate are not physicians but state actors. To avoid sanctions under H.B. 481, medical professionals were forced to deprioritize their own expertise in favor of guessing the ambiguous intentions of state actors. Like the physicians involved in the *Zurawski* case, Smith's care team could not provide appropriate treatment, which would have been to discontinue life support. Instead, encroachment by state legislators impaired the physicians' ability to properly discharge the duties they owed to Ms. Smith.

Another example of state action going beyond accepted police power to promote general welfare and health into concerning encroachment on the medical profession is the push to ban mRNA vaccines in several states. During the 2025 sessions, at least 7 state legislative bodies introduced legislation to ban or heavily restrict the use of mRNA vaccines, including Montana, Idaho, Iowa, Texas, South Carolina, and New York.[199] For example, Iowa's SF 360 would have prohibited administering any "gene-based

5425384/georgia-anti-abortion-fetal-personhood-law-pregnant-woman-life-support [https://perma.cc/63BM-LWMH].

196. H.B. 481, 155th Gen. Assemb., Reg. Sess. (Ga. 2020) ("The State of Georgia, applying reasoned judgment to the full body of modern medical science, recognizes the benefits of providing full legal recognition to an unborn child above the minimum requirements of federal law.").

197. Tanne, *supra* note 194.

198. Mador, *supra* note 195.

199. Stephanie Armour, *MRNA Vaccines, Once a Trump Boast, Now Face Attacks from Some in GOP*, KAISER FAM. FOUND. HEALTH NEWS (Mar. 10, 2025), https://kffhealthnews.org/news/article/mrna-vaccines-trump-boast-under-gop-attacks-legislation/ [https://perma.cc/YMB5-5WAS].

vaccines."[200] Violations would result in a $500 fine per incident and review by the appropriate licensing board. Kentucky's proposal would have prohibited the administration of mRNA vaccines to patients under 18 years of age.[201] A bill in Idaho proposed a 10-year moratorium on mRNA vaccines.[202] Proponents of these bills justify them through a mixture of medical freedom arguments and misinformation about how mRNA vaccines work.[203] For example, the Idaho bill describes vaccines as a "human gene therapy product" even though mRNA vaccines do not modify human DNA. Similarly, the Florida Surgeon General in 2024 issued an official state bulletin calling for a stop to mRNA COVID-19 vaccines due to unsubstantiated safety concerns, despite receiving a December 2023 letter from the FDA summarizing over three years of evidence indicating that mRNA vaccines are safe.[204] To date, although none passed in the 2025 state

200. S.F. 360, 91st Gen. Assemb. (Iowa 2025).

201. S.B. 177, 2025 Gen. Assemb., Reg. Sess. (Ky. 2025).

202. S.B. 1036, 68th Leg., 1st Reg. Sess. (Idaho 2025).

203. *See, e.g.*, Lauren Gardner, *States Eye mRNA Vaccine Limits for a Hesitant Public*, POLITICO (Mar. 11, 2025), https://www.politico.com/newsletters/prescription-pulse/2025/03/11/states-eye-mrna-vaccine-limits-for-a-hesitant-public-00223025 [https://perma.cc/T2F6-EDAA].

204. *Florida Surgeon General Calls to Ban mRNA COVID-19 Vaccines*, PUB. HEALTH COMMC'NS COLLABORATIVE (Jan. 3, 2024), https://publichealthcollaborative.org/alerts/florida-surgeon-general-calls-to-ban-mrna-covid-19-vaccines [https://perma.cc/KG54-2PF8].

legislative sessions,[205] the collective message is clear and public health authorities are concerned that this trend is gaining momentum.[206]

States have indeed been involved with vaccine policy for decades, including setting vaccine requirements for attending school.[207] But using the police power to encourage best public health practices, in dialogue with medical consensus about the value of vaccines and the need for herd immunity, is a different expression of state power from banning vaccines that are considered safe and effective. In the first case, the state acts to guard the welfare and health of its population, as guided by physician leaders. In the second case, the state substitutes its political judgment for the medical judgment of physicians, preventing clinicians from offering this treatment at all to interested patients. A ban on medical technology that is widely regarded as critical and lifesaving is also different from states weakening or repealing their vaccine mandates, because, again, a ban prevents physicians from offering this treatment at all to patients. Banning evidence-based, safe, and effective medical treatments is not a legitimate exercise of states' public health powers, but rather an encroachment on the medical profession's ability to determine appropriate care.

205. The Iowa bill was recommended out of subcommittee; the Texas, South Carolina, New York, Montana, Kentucky, and Idaho bills were left pending in committee. *Billbook*, IOWA LEGISLATURE, https://www.legis.iowa.gov/legislation/BillBook?ga=91&ba=SF360 [https://perma.cc/R4KH-8F95]; *History for 89(R) HB 3176 by Virdell*, TX. LEGISLATURE ONLINE, https://capitol.texas.gov/BillLookup/History.aspx?LegSess=89R&Bill=HB3176 [https://perma.cc/Y2FL-AQWV]; *H.4262*, S.C. LEGISLATURE, https://www.scstatehouse.gov/sess126_2025-2026/bills/4262.htm [https://perma.cc/2FQN-YXQX]; *Senate Bill S7342*, N.Y. STATE SENATE, https://www.nysenate.gov/legislation/bills/2025/S7342 [https://perma.cc/PF8P-UENA]; *H.B. 371: Ban mRNA Vaccinations in Montana for Humans*, MONT. LEGIS. SERVS., https://bills.legmt.gov/#/laws/bill/2/LC1463 [https://perma.cc/R753-LZBC]; *Senate Bill 177*, KY. GEN. ASSEMBLY, https://apps.legislature.ky.gov/record/25rs/SB177.html [https://perma.cc/6SYY-QSVW]; *Senate Bill 1036*, IDAHO LEGISLATURE, https://legislature.idaho.gov/sessioninfo/2025/legislation/S1036/ [https://perma.cc/4VWK-Q485].

206. Gardner, *supra* note 203.

207. *See, e.g.*, Omer et al., *supra* note 48; Carmel Shachar & Dorit Reiss, *When Are Vaccine Mandates Appropriate?*, 22 AMA J. ETHICS E36, E37 (2020).

III. REACTIONS AND SOLUTIONS

Recent attacks on medical and scientific research and evidence-based practices greatly hinder the ability of the medical profession to oversee the practices of physicians and determine the appropriate care to offer patients. In this Section, we describe short-term reactions to these ongoing attacks and propose longer-term solutions. Strategies from professional societies, coalitions of states, and private entities have shown creativity and resolve, aiming to shore up or restore the ability of medical professionals to self-regulate and preserve the physician-patient relationship and effective public health infrastructure.

A. Reactions: Happening in Real Time

The medical profession itself, through collaboration among professional societies and combined medical and public health expertise across state boundaries, is defending and supporting the ability of physicians to deliver appropriate evidence-based care.

1. In the Courts

The Supreme Court cases discussed are part of a dramatically shifting legal landscape. Additional attacks from the executive and legislative branches of federal government in the first nine months of 2025 have inspired multiple lawsuits (413 cases at this writing) aimed at stopping the actions of the Trump Administration related to healthcare and the Department of Health and Human Services.[208]

Plaintiffs in these cases include professional medical organizations and public health organizations such as the American Academy of Pediatrics, the American College of Physicians, the Association of American Medical Colleges, and the American Public Health Association.[209] Also filing suits are coalitions of state attorneys general, in coalitions that parallel the state health alliances specifically formed to coordinate public health

208. *Health Care Litigation Tracker*, O'NEILL INST., https://litigationtracker.law.georgetown.edu [https://perma.cc/23YR-5GB2].

209. *See, e.g.*, Am. Acad. of Pediatrics v. Kennedy, 814 F. Supp. 3d 150 (D. Mass. 2026); Massachusetts v. Nat'l Insts. of Health, No. 1:25-cv-10340, 2025 U.S. Dist. LEXIS 69202 (D. Mass. Apr. 4, 2025), *aff'd*, 164 F.4th 1 (1st Cir. 2026); Am. Pub. Health Ass'n v. Nat'l Insts. of Health, 145 F.4th 39 (1st Cir. 2025).

responses.[210] Plaintiffs are employing a wide range of legal strategies to argue against political actions that encumber medical expertise and limit the autonomy of physicians to practice within well-established medical norms.

The actions these lawsuits challenge would otherwise disable and dismantle the research that supports best medical practices, damaging the ability of expert advisory committees and agencies to disseminate accurate information to clinicians and the public, and creating new conflict between public officials and medical societies. For example, lawsuits from public health organizations and a coalition of states challenge the National Institutes of Health's termination of research grants based on new federal policy priorities.[211] Another case challenges the Agency for Healthcare Research and Quality's stoppage of funding.[212] Medical and public health groups have challenged changes to federal vaccine policies, infrastructure, and regulations.[213] State and local governments have challenged budget cuts to pandemic preparedness and other public health programs.[214] In one notable success, in *Doctors for America v. Office of Personnel Management*, a judge compelled federal agencies to restore health-related data and webpages that had been removed.[215] The original complaint argued that physicians relied on HHS website data for key functions like monitoring and responding to disease outbreaks, and that its removal deprives physicians of information that guides clinical practice and helps them communicate

210. *See, e.g.*, Complaint, Massachusetts v. Oz, No. 1:26-cv-12962, 2026 U.S. Dist. LEXIS 168828 (D. Mass. July 29, 2026); Oregon v. Kennedy, No. 6:25-cv-02409, 2026 U.S. Dist. LEXIS 85354 (D. Or. Apr. 18, 2026); California v. Kennedy, No. 1:25-cv-12019, 2026 U.S. Dist. LEXIS 182153 (D. Mass. Aug. 14, 2026); Massachusetts. v. Kennedy, 783 F. Supp. 3d 487 (D. Mass. 2025); *see also* Jennifer Kates & Josh Michaud, *States Are Forming "Health Alliances." Can They Make a Difference for Public Health Policy?*, KAISER FAM. FOUND. (Oct. 16, 2025), https://www.kff.org/other-health/states-are-forming-health-alliances-can-they-make-a-difference-for-public-health-policy [https://perma.cc/Y3XK-XSPN].

211. Am. Pub. Health Ass'n v. Nat'l Insts. of Health, 786 F. Supp. 3d 237 (D. Mass. 2025); *see also* Massachusetts v. Kennedy, 783 F. Supp. 3d at 491.

212. Complaint, Soc'y of Gen. Internal Med. v. Kennedy, No. 8:25-cv-02751-BAH (D. Md. Aug. 21, 2025).

213. Am. Acad. of Pediatrics v. Kennedy, 814 F. Supp. 3d 150 (D. Mass. 2026).

214. Harris Cnty. v. Kennedy, 786 F. Supp. 3d 194 (D.D.C. 2025).

215. 793 F. Supp. 3d 112, 149-50 (D.D.C. 2025).

with and engage patients.[216] In granting the plaintiff's motion for a temporary restraining order, the judge quoted the attestation of six leading physician groups, noting the lost materials are "vital for real-time clinical decision-making in hospitals, clinics and emergency departments across the country."[217]

If, unlike *Doctors for America*, other efforts of the Trump Administration succeed, physicians and their professional organizations will struggle to tailor their practices to current research, to provide up-to-date accurate information, and to provide appropriate care.[218] Through their court challenges, physicians and other public health actors intend to ensure that appropriate care may continue to be determined by ongoing evaluation of evidence by medical experts, not by political actors.

2. Public Information Efforts

The Administration's inaccurate statements about medical and scientific evidence and the potential lack of reliable health data from public government websites have inspired counteraction in the form of public information and alternative recommendations by professional societies, physician organizations, and state governments.

216. Complaint at 1, 7, 17, Drs. for Am. v. Off. of Pers. Mgmt., 793 F. Supp. 3d 112 (D.D.C. 2025).

217. Drs. for Am. v. Off. of Pers. Mgmt., 766 F. Supp. 3d 39, 56 (D.D.C. 2025).

218. For example, among the many cuts to the CDC, the Administration has eliminated the Reproductive Technology Surveillance and Research Team, an assisted-reproduction data clearinghouse that conducted research into success rates, access, and costs to help tailor practices over time. *See* Roni Caryn Rabin, *Trump Has Called for More Babies but Dismissed Fertility Experts*, N.Y. TIMES (May 7, 2025), https://www.nytimes.com/2025/05/07/health/trump-fertility-ivf-cdc.html. For another example, see *American Academy of Pediatrics v. Kennedy*, which challenged the process by which Secretary Kennedy replaced ACIP membership as well as the recommendations from the reconstituted ACIP. 814 F. Supp. 3d 150 (D. Mass. 2026); *see also* Hughes & Rosenbaum, *supra* note 172; Erika Edwards, *Pediatricians and Other Major Health Groups Are Suing RFK Jr. over Vaccines*, NBC NEWS (July 7, 2025), https://www.nbcnews.com/health/health-news/rfk-jr-sued-pediatricians-medical-groups-covid-vaccines-rcna217218 [https://perma.cc/4RTK-RNXD].

In peer-reviewed journals,[219] on organizational websites,[220] and in media appearances,[221] the most visible leaders in science and medicine have made public statements and recommendations that refute assertions by government agencies and actors, providing information otherwise unavailable to the public because it has been removed from public websites[222] or obfuscated by misinformation.

In addition, in response to the dismantling of the public health infrastructure, voluntary coalitions of states and localities such as the West Coast Health Alliance,[223] the Northeast Public Health Collaborative,[224] and the Governors' Public Health Alliance[225] are working towards "public health emergency preparedness and response, vaccine recommendations and purchasing, data collection and analysis, infectious disease, epidemiology

219. Peter Marks, *Restoring Confidence in Public Health*, 393 NEW ENG. J. MED. 2073, 2075 (2025).

220. *Just the Facts: "Restorative Reproductive Medicine" and "Ethical IVF" are Misleading Terms That Threaten Access*, AM. SOC'Y FOR REPROD. MED., https://www.reproductivefacts.org/patient-advocacy/advocacy-resources/rf-just-the-facts-restorative-reproductive-medicine-and-ethical-ivf-are-misleading-terms-that-threaten-access/ [https://perma.cc/9HXM-S3A7].

221. *The Lead: An OBGYN Weighs In on the Unproven Link Between Tylenol and Autism* (CNN television broadcast 2025), *available at* https://www.cnn.com/2025/09/05/health/video/the-lead-dr-veronica-gillispie-bell-pregnancy-children-autism-tylenol-medicine-jake-tapper [https://perma.cc/4G8Z-8SLL].

222. *See supra* notes 215-217 and accompanying text.

223. Press Release, Governor Gavin Newsom, California, Oregon, and Washington to Launch New West Coast Health Alliance to Uphold Scientific Integrity in Public Health as Trump Destroys CDC's Credibility (Sept. 3, 2025), https://www.gov.ca.gov/2025/09/03/california-oregon-and-washington-to-launch-new-west-coast-health-alliance-to-uphold-scientific-integrity-in-public-health-as-trump-destroys-cdcs-credibility [https://perma.cc/S4R5-7VDP].

224. Joseph Goldstein, *New York and Other States Form Health Bloc as Answer to Trump's Policies*, N.Y. TIMES (Sept. 18, 2025), https://www.nytimes.com/2025/09/18/nyregion/northeast-public-health-collaborative-trump.html.

225. Geoff Mulvihill & Mike Stobbe, *Democratic Governors Form a Public Health Alliance in Rebuke of Trump Administration*, ASSOCIATED PRESS (Oct. 15, 2025), https://apnews.com/article/governors-public-health-alliance-kennedy-7d5f277178697bbdfc228567c6d9f616 [https://perma.cc/VXK3-TEVH].

and laboratory capacity and services."[226] These are voluntary efforts to gather the evidence necessary for public health and medical professionals to make scientifically sound recommendations to the public generally and to individual patients.

Some may critique these efforts as politically motivated and similar to encroachment efforts, in that this movement foregrounds state actors in public health. But these consortiums are constructed to consider the viewpoints of medical and public health experts. This effectively returns the political/medical relationship to an earlier model, in which the state acted to promote the health and welfare of the populace, while medical experts guided the field. On a more practical level, these state collaboratives ensure that ongoing research and data collection allow specific recommendations to evolve over time. But unlike state police power that interferes in the physician-patient dyad, these coalitions preserve the ability of physicians and patients to make evidence-based decisions together, consistent with the standards of evidence to which the medical profession holds itself. State actors should have a role in public health policy but, as these collaboratives illustrate, they must preserve room for medical and scientific expertise, for the physician-patient decision-making dyad, and for the scientific method to continue to refine evidence-based standards of care.

B. Solutions: The Road Ahead

In this Section, we consider longer-term solutions to rebalance the medical and political/legal systems. Our proposals include work to rebuild public trust in the medical profession and encourage political actors to better engage with the scientific method and medical research before substituting their own judgment for that of medical professionals.

1. Rebuilding Trust in the Medical Profession

Trust in physicians and hospitals declined greatly during the COVID-19 pandemic, from 71.5% in April 2020 to 40.1% in January 2024. Researchers suggest investigating whether interventions can rebuild this trust:

226. Press Release, Dep't of Pub. Health, Several Northeastern States and America's Largest City Announce the Northeast Public Health Collaborative (Sept. 18, 2025), https://www.mass.gov/news/several-northeastern-states-and-americas-largest-city-announce-the-northeast-public-health-collaborative [https://perma.cc/GD57-Y8AC].

> Whether interventions to restore trust could increase compliance with vaccination and other positive health behaviors merits further investigation. In particular, our analyses of open-ended results suggest that factors associated with mistrust are heterogeneous, which may require more targeted interventions.[227]

One such intervention might be targeted and coordinated public education efforts. Physicians, public health experts, and patient groups must work together to articulate to the public why self-regulation and insulation from political forces are appropriate and necessary for the medical profession.

The case to be made to patients is that they will lose self-determination in their own medical care when their physicians no longer have the necessary information or the ability and autonomy to govern their own practices and provision of care. True patient autonomy is achieved through collaboration, shared decision-making, and open communication between the patient and physician in an atmosphere of evidence-informed choices within the high standards set by the profession. Evidence-based care standards come from research on larger populations, but individual medical professionals see the individual patient and are best positioned to help them assess health risks and benefits.

The patient-provider relationship permits individuals to make decisions about their own care with their care team, supported by oversight from the profession itself rather than political actors. Some medical information may be complex to a layperson; thus, patients rely on physicians to provide accurate advice. All medical treatments and procedures carry risks and benefits. Principles of individual liberty allow patients to engage in all sorts of risky actions. There will always exist some healthcare providers motivated by profits, popularity, or their own political views instead of providing the standard of care to their patients. Patients, like physicians, require high-quality information and autonomy to make decisions.

Of course, extreme abuses by the medical profession, such as the Tuskegee experiment,[228] reveal what happens to patient autonomy when

227. Roy H. Perlis et al., *Trust in Physicians and Hospitals During the COVID-19 Pandemic in a 50-State Survey of US Adults*, JAMA NETWORK OPEN (July 31, 2024), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2821693 [https://perma.cc/8GFV-RRE5].

228. *See generally* REVERBY, *supra* note 49. Reverby notes that "[m]any see the [Tuskegee] study as a failure from a different time when physician hubris, moral understandings of informed consent, and experimental norms were

the medical profession does not follow basic ethical rules. The Belmont Report and the parallel development of bioethics were responses to Tuskegee and other abuses by the medical profession in the early to mid-twentieth century.[229] The field of bioethics and principalism (or the approach in bioethics that uses key principles to guide ethical decision-making) specifically draws upon a "common morality,"[230] and thus is in part an attempt to articulate how community values and norms could be incorporated into the medical system if consistent with evidence and found to result in proven benefit. To rebuild trust, we believe the profession must self-regulate to ensure that healthcare is supported by evidence and that professional societies and state licensing boards are prepared to take action to protect patients, such as imposing fines or modifying, suspending, or revoking licenses to practice medicine where physicians are incompetent or act unprofessionally. Additionally, the medical profession must work harder on transparency, to make it understandable to the public what motivates its decision-making and norms. Assuring and insisting on a system grounded in evidence-based medicine through visible expert oversight from other members of the medical profession will help deter reliance on misinformation and bad outcomes.

Evidence-based medicine must be at the core of all the choices available to the patient and their provider. When political actors such as federal or state legislators or judges create new rules, they impose additional *legal* risk for providing care. As is most obvious from restrictions on abortion care post-*Dobbs* and gender-affirming care after *Skrmetti*, political intervention means that medical professionals are less able to counsel their patients, and hospitals are forced to be cautious in ways that may be inconsistent with the gold standard of medical care.[231]

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less sophisticated," and that "[u]ltimately, what happened in the study is about how varying kinds of assumptions about race can fill in the uncertainty that is central to medicine." *Id.* at 4-5.

229. *The Belmont Report*, THE NAT'L COMM'N FOR THE PROT. OF HUM. SUBJECTS OF BIOMEDICAL AND BEHAV. RSCH. 5 (1979), https://www.hhs.gov/ohrp/sites/default/files/the-belmont-report-508c_FINAL.pdf [https://perma.cc/5UVL-NN7D].

230. *See generally* Tom L. Beauchamp, *A Defense of the Common Morality*, 13 KENNEDY INST. ETHICS J. 259 (2003) (proposing the existence of a common morality and defending it in terms of: (1) a theory of the objectives of morality; (2) an account of the norms that achieve those objectives; and (3) an account of normative justification, both pragmatic and coherentist).

231. Sarah M. Hall & Elena M. Quattrone, *The Impact of Dobbs: Enforcement Risks to Expect and Monitor* (June 30, 2022),

2. Making the Case for Public Health Mandates

Self-regulation does have exceptions; sometimes legal or policy actions are necessary to preserve public health and/or avoid harm. But today, previously uncontroversial public health policies like fluoride in the water supply are under attack.[232] Medical experts today must regain the public trust in order to protect the public through widespread public health mandates.

Public health mandates took on a bad reputation during the COVID-19 pandemic. As Michelle M. Mello and Lawrence O. Gostin have written, mask mandates and school closures during the COVID-19 pandemic may have hurt public confidence in public health as a discipline and revealed how public health powers may benefit from "rebalancing." They note that "courts and state legislatures have cut deeply into emergency powers, jeopardizing future emergency response" and call for legislators to "modernize emergency powers laws to balance powers and individual rights in more productive ways."[233] Governors and state legislatures have also attempted to narrow public health powers, in response to the pandemic, by attempting to end vaccine mandates or to issue gag orders on departments of public

https://www.commerciallitigationupdate.com/the-impact-of-dobbs-enforcement-risks-to-expect-and-monitor [https://perma.cc/N2QE-EKBC].

232. Food & Water Watch, Inc. v. United States Env't Prot. Agency, No. 17-cv-02162-EMC, 2024 U.S. Dist. LEXIS 172635, at *5-6 (N.D. Cal. Sept. 24, 2024).

233. Michelle M. Mello & Lawrence O. Gostin, *Public Health Law Modernization 2.0: Rebalancing Public Health Powers and Individual Liberty in the Age of COVID-19*, 42 HEALTH AFFS. 318, 318 (2023).

health to prevent them from promoting vaccines.[234] Some are still contesting public health decisions from the COVID-19 pandemic.[235]

In the aftermath of the pandemic, medical experts have work to do in order to rebuild the trust necessary for public health mandates to work.[236] Critically, experts need to carefully frame the role that uncertainty plays in public health and medicine. It is critical to convey to the public that public health efforts are based upon the best scientific evidence available *at the time*. But uncertainty is part of medicine. In spite of, or perhaps because of this uncertainty, most medical experts believe strongly that implementing bans on certain types of healthcare in the face of uncertainty is never the right answer, because banning care removes the ability to continue to study its outcomes.[237] The COVID pandemic was a time of tremendous

234. Will Stone, *So Far, Florida Has Failed to End Vaccine Mandates. Now There's a Last-Ditch Effort*, NPR (Apr. 28, 2026), https://www.npr.org/2026/04/28/nx-s1-5798698/florida-school-vaccine-mandates-ladapo-desantis [https://perma.cc/JYS4-DUH2]; Press Release, Governor Greg Abbott, Governor Abbott Issues Executive Order 39 Prohibiting Vaccine Mandates in Texas (Aug. 25, 2021), https://gov.texas.gov/news/post/governor-abbott-issues-executive-order-39-prohibiting-vaccine-mandates-in-texas [https://perma.cc/FPN3-NXV7]; Rosemary Westwood, L*ouisiana Forbids Public Health Workers from Promoting COVID, Flu and Mpox Shots*, NPR (Dec. 20, 2024), https://www.npr.org/sections/shots-health-news/2024/12/20/nx-s1-5223440/louisiana-ban-public-health-promoting-covid-flu-mpox-vaccines-landry-rfk-jr-anti-vaccine [https://perma.cc/XPL4-2ZE7].

235. Kate Zernike, Emily Cochrane & Isabelle Taft, *Public Health Survived the Pandemic. Now It Fights Politics*, N.Y. TIMES (Mar. 13, 2025), https://www.nytimes.com/2025/03/13/us/public-health-covid-pandemic-politics.html.

236. *See* Daniel J. Morgan & Deborah Korenstein, *Public Health for the Post-COVID-19 Public*, JAMA HEALTH F. (Dec. 5, 2025), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2842292 [https://perma.cc/5PKG-X8MH].

237. *See, e.g.*, IMOGEN EVANS, HAZEL THORNTON, IAIN CHALMERS & PAUL GLASZIOU, TESTING TREATMENTS: BETTER RESEARCH FOR BETTER HEALTHCARE 50-64 (2d ed. 2011) (discussing the ubiquitous nature of uncertainty in medicine, the key need for continued rigorous trials, not bans, and the need for discussion and disclosure of uncertainty to patients in shared decision-making); Cass, *supra* note 117, at 13, 40 (concluding that evidence for youth gender-affirming care is weak and thus further study is warranted in formal research studies; cautioning against a ban of the medication for this purpose); Patrick Boyle, *What's at Stake when Clinical Trials Research Gets Cut*, AAMCNEWS (Apr. 24, 2025),

uncertainty, and this uncertainty created new opportunities for medical professionals to help the public with their expertise. Scientists and physicians around the world raced to find effective treatments and vaccines and adjusted their recommendations as new information became available—information that was made possible by ongoing collection of evidence in the face of uncertainty.

A new generation of epidemiologists and medical experts, such as Katelyn Jetelina (with her substack "Your Local Epidemiologist")[238] and Caitlin Rivers (with her newsletter "Force of Infection")[239] are working to rebuild trust in the public health system, reaching out to collaborate with "minority view" groups on areas of mutual interest, in hopes of building bridges by carefully exploring topics with a strong evidence base. Similar work is being done in the podcast *Why Should I Trust You?*, in which journalists bring together a virologist and dermatologist to have discussions with "Make America Healthy Again" leaders.[240] These transparency efforts are critical in making the medical profession understandable to the broader community and, therefore, building trust in the public health apparatus.

3. Next Steps for Political Actors in Healthcare

State actors in healthcare can take certain steps to ensure that their involvement is productive rather than purely political. In this Section, we flag ongoing efforts and provide a suggestion for political actors working in this sphere, acknowledging that encroachment is a broad-enough trend that it can be mitigated but perhaps not entirely eliminated.

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https://www.aamc.org/news/whats-stake-when-clinical-trials-research-gets-cut [https://perma.cc/43NS-JHC9] (showing how federal funding freezes in part related to political action against "diversity, equity, and inclusion" programs stifle clinical research and stop experimental trials, which ultimately prevents scientific progress); Beth Faiman, *The Impact of Federal Funding Cuts on Research, Practice, and Patient Care*, 16 J. ADVANCED PRAC. ONCOLOGY 124, 124 (2025).

238. Katelyn Jetelina et al., *Odd Bedfellows: Moving with MAHA From Conversation to Collaboration*, YOUR LOC. EPIDEMIOLOGIST (July 30, 2025), https://yourlocalepidemiologist.substack.com [https://perma.cc/Y3WE-JXSY].

239. Caitlin Rivers, *Outbreak Outlook - West - Nov 23*, FORCE OF INFECTION (Nov. 23, 2025), https://www.forceofinfection.com/ [https://perma.cc/685Z-T7YK]

240. WHY SHOULD I TRUST YOU?, https://www.whyshoulditrustyou.net [https://perma.cc/ZZ2W-2TV3].

Specific limited legislative efforts are already underway to address some of the fallout from recent encroachment on medical professionals' ability to provide care and return to the profession the ability to self-regulate. The most immediate examples come from "shield" laws like those recently enacted in New York.[241] Shield laws aim to protect clinicians practicing in states where legally contested healthcare services are permitted by shielding them from legal action for providing these services to patients in states where they are not permitted.[242] Such laws aim to protect physicians' decision-making, but they run the risk of seeming purely political. Amidst the proliferation of state shield laws,[243] there has been counteraction including interstate court challenges from states like Louisiana and Texas, and requests from Republican-led state attorneys general that Congress act to preempt state shield laws altogether.[244] The legal future of shield laws remains uncertain, including how effective they will be against the encroachment efforts of other state actors. Therefore, proponents of evidence-based care must not only sue, but also reach out to these unorthodox challengers of the medical establishment and the status quo.

This is especially true because political actors will be reluctant to give up their territory. The medical profession (and society more broadly) must grapple with how to preserve room for dissent within an acceptable evidence-based standard of care. Care that does not withstand scientific inquiry should not be acceptable, although at times "minority views" are permitted within the acceptable standard of care. Potential weakening of the profession-determined standard of care and standards of expertise in

241. N.Y. EXEC. LAW § 837-X (2024); Kimya Forouzan, *Shield Laws Related to Sexual and Reproductive Health Care*, GUTTMACHER (July 14, 2025), https://www.guttmacher.org/state-policy/explore/shield-laws-sexual-and-reproductive-health-care [https://perma.cc/35MW-L95U].

242. Carmel Shachar, Sravya Chary & Morgan Carmen, *Providing Interstate Telehealth Abortion Services to Patients in Restrictive States*, 392 NEW ENG. J. MED. 417, 419 (2025).

243. *Shield Laws for Reproductive and Gender-Affirming Health Care: A State Law Guide*, UCLA L., https://law.ucla.edu/academics/centers/center-reproductive-health-law-and-policy/shield-laws-reproductive-and-gender-affirming-health-care-state-law-guide [https://perma.cc/3X4B-G84P].

244. Alejandra O'Connell-Domenech, *Republican States Press Congress to Ban Abortion Shield Laws*, HILL (July 30, 2025), https://thehill.com/policy/healthcare/5427732-republican-states-target-abortion [https://perma.cc/H3EA-UFLU].

malpractice litigation are not acceptable. We must protect patients' access to the kind of care that the profession has approved and proven safe. This is not to say that the balancing between protecting patients from unsafe care and preserving room for dissenting (and, at times, innovative and transformative) opinions is easy. But again, the scientific method, with its emphasis on continued research and experimentation, can be an important and helpful approach to allow for dissent and innovation while also articulating what safe and effective care looks like at the moment, to the best of the profession's knowledge.

We expect to see continued litigation to protect evidence-based care and the process and study necessary to establish that evidence base. However, we also believe engaging with dissenting viewpoints is critical, so long as all parties are operating in good faith and on principles of scientific inquiry with a goal of best evidence. We urge lawmakers from all perspectives with genuine interest in improving public health and the standard of medical care to engage deeply with the scientific method.

Recent trends at the state level are cause for optimism as legislators and state actors across the political spectrum see the value in engaging deeply with data and evidence. Legislators have long professed a desire to adhere to evidence in their work, and it is reasonable to hold them to this standard. With the passage of the Foundations for Evidence-Based Policymaking Act of 2018,[245] the United States government now requires that agencies create public data inventories, make data "open by default," and improve data management practices with the ultimate goal of creating evidence to guide policy decision-making.[246] Similar efforts are underway in more than a dozen states, including Maryland, Illinois, Colorado, Oklahoma, Mississippi, and Indiana.[247] The state-funded New Jersey State Policy Lab at Rutgers University has produced data-driven reports on such topics as telemedicine's impact on health equity gaps and the COVID-19 pandemic's

245. Pub. L. No. 115-435, 132 Stat. 5529 (2019).

246. § 202(b), 132 Stat. at 5535; *Two Years of Progress on Evidence-Based Policymaking in the United States*, DATA FOUND. (Sept. 6, 2019), https://datafoundation.org/news/blogs-evidence-informed-decision-making/162/162-Two-Years-of-Progress-on-Evidence-Based-Policymaking-in-the-United-States [https://perma.cc/MQU9-YVNL].

247. *Putting the Proof in the Pudding: How State Legislatures Are Using Evidence to Drive Better Results*, NAT'L CONF. STATE LEGISLATURES, https://www.ncsl.org/center-for-results-driven-governing/putting-the-proof-in-the-pudding-how-state-legislatures-are-using-evidence-to-drive-better-results [https://perma.cc/PP5A-8ZFR].

effects on childcare.[248] In short, our government is slowly moving toward a data-driven scientific approach to policymaking. Adhering to this level of respect for evidence is the key but can be difficult to achieve in the setting of highly politicized topics.

Overall, we acknowledge that the trend is for state actors to be more and more involved in healthcare and public health policy. The ACA was a massive shift in the federal government's involvement in healthcare. The COVID-19 pandemic illustrated that public health is not a backwater academic field but an area of public policy that can significantly shape lives. And *Dobbs* recemented that many in our country do not agree on what ethical care looks like. But even as federal and state actors rush in to set their mark on the healthcare landscape, we want to emphasize that they need, at minimum, to understand the scientific method of arriving at evidence-based standards of care. This does not ask them to come to the same conclusions as physicians always do but will help ensure that their decisions serve the interests of patients, who deserve access to safe and effective care.

CONCLUSION

State actors have at times, historically, regulated the healthcare system and, with that regulation, limited the ability of the medical profession to self-regulate. These times, however, were relatively limited and focused on promoting public health and safety. The medical profession was allowed to self-regulate, meaning that it could set norms around what care was appropriate to offer patients, determine who was qualified to offer this care, and police those boundaries when violated.

We are currently seeing a dramatic realignment of the medical and legal/political systems. The seeds of this realignment may have been planted decades ago in cases about abortion access, such as *Gonzales v. Carhart*[249] and *Stenberg v. Carhart*.[250] But encroachment upon the medical profession has dramatically accelerated in the last few years, post-*Dobbs* and post-COVID-19 pandemic. We are seeing courts allow states to ban medical services when there is "medical uncertainty," despite this possible uncertainty suggesting that a better course would be further research and refinement of medical practices. There is a hollowing out of the medical and scientific expertise from expert advisory committees in federal

248. *Id*.

249. 550 U.S. 124 (2007).

250. 530 U.S. 914 (2000).

administrative agencies, which in turn drives a wedge between agency recommendations and medical society recommendations. States are also aggressively regulating in this space, on issues such as vaccine access and gender-affirming care, often to further political goals rather than achieve best medical care.

A significant problem with encroachment is that these political actors are not trained to engage with medical and scientific data. For example, in many scenarios, the justification for encroachment is uncertainty within the medical practice. But uncertainty is to be expected with the scientific method, because it is a system that is constantly seeking to refine and improve on practices. Clinicians make decisions based on the best evidence they have at the time and the relative risk and benefit to patients, as well as the patient's personal preferences and beliefs. The medical profession has generally permitted individual clinicians the autonomy to make decisions based on risks and benefits of different options, taking into consideration the needs and circumstances of the patient they are treating. But the encroaching political actors cut that process short, undermining the ability of providers and patients to engage in medical decision-making.

To combat encroachment and to mitigate some of its flaws, the medical profession must focus on rebuilding trust. Professional self-regulation can only occur when there is sufficient trust in the professional actors to be "guarding the hen house." Some of this trust building must be to better allow for dissent and minority views within the accepted evidence-based standard of care as well as better engagement with popular movements focused on health. But the medical profession must also consider that political actors will be reluctant to give up some of the territory they have encroached upon. So, another goal should be to find ways to encourage these encroachment actors to engage with data and adopt the scientific method in their decision-making with the help of established experts. Better education of judges on research methods and healthcare delivery, for example, could help guide judicial decision-making, especially when faced with "dueling experts." Encroachment is a well-established trend by now. In order to survive it and continue delivering high-quality care to patients, the medical profession must both rebuild trust in itself and teach political actors the value of the scientific method to drive healthcare and public health policy.