Health panels, policies, and politics

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Early last month, the American Medical Association **announced** a collaboration with the **Vaccine Integrity Project** to create an "evidence-based review process to assess vaccine safety and effectiveness for the 2026–27 respiratory virus season," focusing on influenza, Covid-19, and RSV. Founded in 2025, the VIP is housed at the University of Minnesota's Center for Infectious Disease Research and Policy.

This announcement was **unusual** coming from a professional membership association that primarily focuses on reimbursement, billing practices, and the economics of medical practice. Yet it was not surprising in another sense: the AMA–VIP effort appears designed as a counterbalance to the newly appointed members of the CDC's Advisory Committee on Immunization Practices **(ACIP)** .

The AMA's initiative is novel because it places the organization squarely in the realm of broad public health evidence review — an area it has not traditionally led. This new collaborative seeks to position itself as a highly credentialed reviewer of vaccine evidence, implicitly contrasting itself with the reconstituted ACIP panel. Still, the existence of more than one "expert panel" offering medical or public health recommendations is nothing new. Nor is it surprising that political circumstances shape how scientific evidence is reviewed, interpreted, and translated into policy.

A prominent example is the 2009 change in the **U.S. Preventive Services Task Force** (USPSTF) breast cancer screening guidelines. That November, the

USPSTF recommended biennial screening for women ages 50 to 74 and individualized decisions for women ages 40 to 49 — a major shift from long-standing guidance, supported by advocacy groups like the **American Cancer Society**, urging annual screening beginning at 40. Modeling commissioned by the National Cancer Institute supported the Task Force's conclusion that starting routine screening at 50 provided the best balance of clinical benefits and harms.

Despite this evidence-based recommendation, the federal government did not change insurance reimbursement to match the new start age. The result was a **public relations challenge** for then–DHHS Secretary Kathleen Sebelius. Advocacy groups were split: some feared a setback in encouraging early detection, while others argued that decades of awareness efforts had not **delivered enough progress** in prevention and treatment despite major fundraising. Sebelius ultimately emphasized that the **USPSTF "does not set federal policy,"** highlighting the sometimes-selective use of science when policy pressures intervene.

Such dynamics reflect a broader truth: while federal agencies generally respect the expertise of their advisory panels, they also maintain distance when recommendations conflict with political, social, or financial pressures. As Thomas Kuhn famously argued in ***The Structure of Scientific Revolutions***, scientific progress is not a steady accumulation of facts but a series of paradigm shifts—often sparked by those who question the prevailing framework. Disruption is part of scientific advancement, yet it is also inherently destabilizing.

In that context, **DHHS Secretary Robert F. Kennedy, Jr.** is raising questions about vaccine recommendations and mandates. Whether one agrees with him or not, he has been cast as a *persona non grata*. We should be cautious that opposition to his department's work is driven by rigorous public health reasoning — not by political reflex. Good policy requires: (1) intellectually honest inquiry into the nature and extent of a health problem, and (2) reasonable, defensible alternatives for addressing it.

Given recent history, it is understandable that both the public and healthcare providers are reluctant to accept expert recommendations. After the Covid-19 response, CDC director Dr. Rochelle Walensky prioritized **restoring trust in the 75-year-old agency**. She initiated a comprehensive internal review, acknowledging that the agency had struggled with communication, decision-making, and excessive entanglement with political considerations. Public health professionals,**like some journalists**, have at times drifted from their traditional roles — shifting toward advocacy and political engagement rather than focusing on objective communication and community protection.

During the Covid-19 debates, confidence among scientific leaders sometimes crossed into hubris. Dr. Anthony Fauci's assertion that **he "represent[s] science"** became emblematic of the tension between expert authority and public skepticism. Such moments fueled concerns that public health messaging had become intertwined with political identity rather than grounded solely in evidence.

So, what should patients and families do when confronted with conflicting recommendations from competing expert panels? The answer remains the same: rely on individualized clinical judgment. Medical decisions should be grounded in a patient's full medical history, current health status, and presenting symptoms. Expert guidance matters, but it must be **interpreted through the lens of the individual patient.**

This raises a central question: can you trust your physicians? That depends on the trust you place in them as professionals — and, similarly, the trust that providers place in advisory committees hinges on the credibility and transparency of those bodies.

Unfortunately, trust in **healthcare** and **public health** "experts" has declined sharply, largely due to missteps and inconsistent communication. Rebuilding that trust will take years. What hangs in the balance is not merely institutional credibility but the health of the nation itself.

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