IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

West Virginia Board of Education, Nancy J. White, in her capacity as President of the Board of Education, Victor Gabriel, F. Scott Rotruck, L. Paul Hardesty, Robert W. Dunlevy, Christopher Stansbury, Deborah Sullivan, Gregory Wooten, Sarah Armstrong Tucker, and Cathy Justice all in their capacities as members of the West Virginia Board of Education, Michelle Blatt, in her official capacity as State Superintendent of Schools, Raleigh County Board of Education, Larry Ford, Richard Snuffer, Charlotte Hutches, Marie Hamrick, and Marsha Smith, all in their official capacities as members of the Raleigh County Board of Education, and Serena L. Starcher, in her official capacity as Superintendent, Raleigh County Board of Education, and Jane Doe

Petitioners,

v. **Case No. 25-836**

MIRANDA G., individually and on behalf of her minor child A.G., and Carley H., individually and on behalf of her minor E.G.

Respondents.

AMICUS CURIAE BRIEF BY CHILDREN'S HEALTH DEFENSE

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STATEMENT OF IDENTITY AND INTEREST[1]

Over the last thirty years, chronic illness among children has reached epidemic proportions.[2] Children's Health Defense ("CHD") is a nonprofit organization whose mission is to end the childhood chronic disease epidemic by reducing the toxic environmental exposures that underlie it, especially where those exposures are involuntary. CHD seeks to hold responsible parties accountable[3] and to establish safeguards to prevent future harm to children's health, including the prohibition of vaccine mandates that threaten the ability of parents to exercise fundamental religious liberties on their children's behalf.

CHD has a strong interest in the outcome of this case. First, at the core of its mission, CHD seeks to protect religious freedom, parental rights, and health freedom. Fighting to protect these fundamental rights, CHD regularly challenges in both state and federal courts nationwide attempts to constrain these rights. Further, CHD, through legal, advocacy, scientific, and educational initiatives, regularly confronts, challenges, and dismantles incomplete and misleading vaccine science narratives, like those advanced here by the Petitioners' *amici* Health Advocacy Organizations ("HAOs"), including, in particular, the American Academy of

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[1] Under W.V. Rules of Appellate Procedure, Rule 30(e)(5), CHD states that no counsel for any party authored this brief in whole or in part and no entity or person, aside from CHD, its members, and counsel, made any monetary contribution toward the preparation or submission of this brief. Finally, no other person who would need to be identified under Rule 30(e)(5) made a monetary contribution toward this Brief.

[2] *See* Christopher B. Forrest et al., *Trends in US children's mortality, chronic conditions, obesity, functional status, and symptoms*, 334 JAMA 6:509–516 (2025); Enrique Rivero, *Pediatric chronic disease has risen nearly 30% in the last 20 years*, UCLA Health (March 10, 2025), https://www.uclahealth.org/news/release/pediatric-chronic-disease-prevalence-has-risen-nearly-30; CDC, Managing Chronic Conditions, https://www.cdc.gov/school-health-conditions/chronic-conditions/index.html; *Make America Healthy Again Commission Report* (May 22, 2025) (documents exploding rates of chronic illness in children and systematic retaliation against dissenting physicians). https://www.whitehouse.gov/wp-content/uploads/2025/05/MAHA-Report-The-White House.pdf (hereinafter "MAHA Report").

[3] Indeed, CHD's suit against the AAP for RICO violations is currently pending in the United States District Court for the District of Columbia. *See* Complaint, *Shaw v. American Academy of Pediatrics*, No. 1:26-cv-00171 (D.D.C. filed Jan. 21, 2026).

Pediatrics ("AAP") and the Infectious Diseases Society of America ("IDSA"). Governmental entities, courts, and even private industry - often with inadequate or no analysis - rely upon the HAOs' incomplete and misleading science to deny religious liberty, parental rights, and health freedom to families such as Respondent here. As shown below, there are significant conflicts of interest, including financial conflicts, between the HAOs and the pharmaceutical industry that warrant this Court exercising increased critical scrutiny of the HAOs' claims in their amicus briefs.

BACKGROUND

CHD believes the background below will provide the Court with context to understand the significance of the HAOs' conflicts of interest and why the Court must consider those conflicts in assessing the HAOs' amicus briefs.

In the first instance, we must go back forty years to understand the shift in the legal landscape surrounding vaccines, which largely laid the groundwork for these conflicts of interest to flourish. In 1986, due to a growing number of serious injuries and deaths associated with recommended childhood vaccines, verdicts against vaccine manufacturers awarding damages to victims, and threats by vaccine manufacturers to exit the market, Congress passed the National Childhood Injury Act of 1986 (42 U.S.C. §§ 300aa-1, *et seq.*) (the "1986 Act"). The 1986 Act afforded vaccine manufacturers essentially complete immunity from liability for vaccine-induced harms relating to shots on the federally recommended childhood immunization schedule. No other private industry is so untouchable.

With this liability shield in place, manufacturers introduced an ever-increasing number of vaccines for children. These vaccines, with little scientific support regarding safety and efficacy,

were recommended by the federal government and mandated by states.[4] The vaccine liability shield not only permits manufacturers to enjoy over seventy billion dollars in yearly revenue with no downside – the shield has destroyed the incentives to research vaccine safety and efficacy and, in particular, the relationship between vaccines and children's health.[5] Coincident with this increasing vaccine schedule, however, children's health in the United States has declined precipitously.

Through various programs and distribution streams, -vaccine manufacturers have funded -advocates styled as non-profit HAOs (including several of Petitioners' *amici* here). Sadly, these amici have remained, at best, incurious about or, at worst, complicit in covering up a connection between vaccines and the ominous downward trend in children's health. That these HAOs enjoy substantial financial support from the pharmaceutical industry raises serious questions about their true allegiances.

Nearly all such institutions parrot the vaccine manufacturers' "safe and effective" marketing campaigns, disregarding significant gaps in vaccine science and research - particularly the safety of vaccines individually, as well as the cumulative impact of the vaccine schedule. As set forth below, it is critical to note that Petitioners' amici curiae purposefully omit indisputable evidence concerning the safety and risks of the childhood vaccines at issue. Unfortunately, many of these pharma-friendly HAOs, particularly the AAP and the IDSA, enjoy substantial influence in the realm of policy-making, guidelines development, and state-level vaccine mandates - all while benefitting from industry payments in various forms, discussed in more detail below.

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[4] See, CDC Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/child/0-18yrs-child-combined-schedule.pdf (Last viewed May 6, 2026).

[5] Indeed, although there is a compensation system under the 1986 Act, the program is funded by a 75 cent excise tax on vaccines that manufacturers pass off to purchasers, eliminating any incentive or downside to the tax. *See* I.R.C. § 4131.

In 2025, the vaccine market represented approximately $72.75 billion in total sales and is expected to rise to approximately $155.77 billion by 2033. *See* Grand View Research, *Vaccine Market Size, Share & Trends Analysis Report*, (2025), https://www.grandviewresearch.com/industry-analysis/vaccine-market. Given the amount of money flowing through this industry (with zero headwinds due to immunity under the 1986 Act), it is no surprise that the pharmaceutical industry makes available to HAOs tremendous financial incentives to promote the pharmaceutical companies' marketing. In fact, the vaccine marketing complex permeates nearly every HAO and research university in this country via donations, grants, and other perks of association, including board positions. *See, e.g.*, Merck grants from 2021-2025, identifying major HAOs in the United States, including AAP, as recipients of Merck grants.[6, 7]

The conflicts between HAOs and the vaccine industry are not only systemic, but also specific in some well-documented instances to individual amici in this case; the HAOs' joint brief claims to be public health policy advocacy but is framed in what ultimately is the unsupported and unsupportable guise of scientific certainty.

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[6] https://www.merck.com/wp-content/uploads/sites/124/2025/01/GMPEA-2024-Transparency-Data.pdf; https://www.merck.com/wp-content/uploads/sites/124/2024/01/gPRIME-2023_Transparency_Data.pdf; https://www.merck.com/wp-content/uploads/sites/124/2023/07/gPRIME_2022_Transparency_Data.pdf; https://www.merck.com/wp-content/uploads/sites/124/2022/04/gPRIME-2021-Transparency-Data.pdf

[7] The pharmaceutical company marketing ecosystem further extends to billions of advertising dollars flowing to news and other media sources. *See* Paul Hiebert, *Where Pharma's $12B TV Ad Budget Could Go Next*, Adweek (Mar. 4, 2025), https://www.adweek.com/brand-marketing/pharmas-12bn-tv-ad-budget/ (citing data from WARC). Additionally it extends to lobbying in Washington D.C., where the pharmaceutical industry is the highest-spending industry, spending approximately $450 million in 2025 alone. The industry also spends significant amounts on lobbying and PAC funding on the state level, including in support of West Virginia candidates. *See, e.g.*, Merck 2024 PAC financing disclosure totalling $900,000,000, including PAC contributions to West Virginia candidates, https://www.merck.com/wp-content/uploads/sites/124/2025/03/2024-U.S.-Corporate-PAC-Contributions.pdf; *See* OpenSecrets, *Pharmaceuticals/Health Products: Industry Profile* (2025) https://www.opensecrets.org/federal-lobbying/industries/summary?id=H04;

We will address both systemic issues of conflict of interest as well as conflicts specific to certain amici, whose conflicts have been and continue to be investigated and documented. CHD encourages the Court to focus on the legal questions before it of the State's unconstitutional burdens on religious free exercise and parental rights, and to reject Petitioners' amici's purported public health claims concerning vaccination based on cherry-picked science.

ARGUMENT

I. The Court Should Scrutinize Submissions By Amici Health Advocacy Organizations Because These Organizations and Their Membership Are Rife With Conflicts Due to Pharmaceutical Industry Influence

Financial as well as governance conflicts in the form of weak conflict of interest policies and hiring of pharmaceutical company executives/employees create a risk of dependence and coerced alignment. This ecosystem creates systemic conflicts of interest and compromises the independence of organizations that legislators, regulators, courts, and the public rely upon to represent patient interests free from commercial bias.

A substantial and growing body of peer-reviewed scholarship, legal analysis, and investigative journalism establishes that non-profit HAOs, most particularly the AAP and IDSA, have received billions of dollars in financial support — including grants, donations, and sponsorships — from pharmaceutical companies. Indeed, HAOs like AAP and IDSA have significant influence and often develop treatment guidelines and recommendations for certain diseases that are ultimately incorporated into mandates and insurance coverage limitations. Pharmaceutical funding to these organizations operates largely without transparency, since there is essentially no legal obligation for HAOs to disclose this information.[8] Yet these organizations

[8] The Physicians Payments Sunshine Act requires only covered physicians and teaching hospitals - not HAOs - to declare direct gifts and funding from such companies. 42 CFR § 403.902. This law has no real effect if the physicians fail to disclose those conflicts when advocating or developing guidelines. After this law increased scrutiny of physician payments, pharmaceutical companies apparently shifted toward funding HAOs to maintain

misleadingly hold themselves out as unbiased sources of information - or even as purportedly patient-centric - which is far from the truth.

In 2009, the Institute of Medicine (IOM)[9] published a report regarding the problem of the pharmaceutical industry's influence on medicine, and particularly financial conflicts between pharma and individual doctors, researchers, and research institutions. *See* Inst. of Med., Comm. on Conflict of Interest in Med. Rsch., Educ., & Prac., *Conflict of Interest in Medical Research, Education, and Practice* (Bernard Lo & Marilyn J. Field eds., 2009). The report noted a lack of transparency on all fronts, including by groups that develop clinical practice guidelines, like amici AAP and IDSA. It noted the risk of inappropriate influence on the guideline process, including bias in recommendations and harm to patients because guidelines may influence physician practice behavior, quality improvement measures, reimbursement incentives, and insurance coverage decisions. *Id.*

To the extent these HAOs have any conflict of interest policies applicable to employees who author research or clinical treatment guidelines, these policies are weak, and there is no transparency regarding follow-up investigations when conflicts are discovered. Moreover, as detailed below, a large percentage of HAOs (including AAP and IDSA) have been caught violating those policies. Though some HAOs provide generalized information about their organizational funding and pharmaceutical industry connections, it is not possible to trace the total sum of industry funding to each without some form of mandated disclosure, particularly

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policy influence through ostensibly independent voices. Since the Act constrained direct cooptation of physicians, the industry turned to patient advocacy organizations as alternative "megaphones." *See* Emily Kopp, Sydney Lupkin & Elizabeth Lucas, *Patient Advocacy Groups Take In Millions From Drugmakers. Is There A Payback?*, KFF Health News (Apr. 6, 2018), https://kffhealthnews.org/health-care-costs/patient-advocacy-groups-take-in-millions-from-drugmakers-is-there-a-payback/.

[9] The IOM (now renamed The National Academy of Medicine) is an independent, nonprofit, non-governmental organization that serves as a trusted, nonpartisan advisor to the U.S. government, policymakers, and the public on matters of health, medicine, biomedical science, and health policy.

given the increased availability of funding mechanisms that obfuscate the true source of payment.

A. Financial Conflicts Risk Dependency and The Silencing of Non-Pharma Aligned Views

The most fundamental conflict between pharmaceutical companies and HAOs is the raw financial relationship, including donations, grants, perks for physicians, and advertising dollars via HAO publications. The scale of this funding is not marginal — it is one of the pharmaceutical industry's primary expenditure categories, and its reach is staggering. For example, just a single pharmaceutical industry group, PhRMA (and its 31 member companies) provided at least $6 billion in grants to *more than* 20,000 organizations between 2010 and 2022. *See* Pub. Citizen, *Mapping the PhRMA Grant Universe: An Analysis of the $6 Billion in Grants Distributed by PhRMA and Its Member Companies* (Dec. 15, 2023), https://www.citizen.org/wp-content/uploads/PhRMA-Grant-Universe.pdf (survey found more than 460 organizations receiving money from five or more PhRMA Network entities, more than 70 organizations receiving money from 10 or more PhRMA Network entities, and that 13 of the nation's largest and most powerful patient advocacy organizations received $266 million from the PhRMA Network alone).[10]

In addition to donations to HAOs, the pharmaceutical industry awards grants, which are often strategically directed toward advocacy organizations in disease areas in which a company has commercial products, creating a direct nexus between funding and marketing interests. For

[10] *See also* Matthew S. McCoy et al., *Conflicts of Interest for Patient-Advocacy Organizations*, 376 New Eng. J. Med. 880 (2017) (Study analyzing tax records, annual reports, and websites of 104 U.S.-based patient-advocacy organizations, excluding professional organizations, determined that 83% of the 104 largest U.S. patient advocacy organizations explicitly reported receiving pharmaceutical industry support); Susannah L. Rose, et al., *Patient Advocacy Organizations, Industry Funding, and Conflicts of Interest*, 177 JAMA Internal Med. 344 (2017) (National survey of 439 [H]AO leaders, found that 67% of patient advocacy organizations reported receiving some industry funding; 12% received more than half their revenue from industry).

example, a 2011 study examining Eli Lilly's publicly disclosed grant registry provides direct evidence that pharmaceutical grants follow marketing priorities rather than public health need; it showed 94% of the $3.2 million disbursed to advocacy groups in the first two quarters of 2007 were concentrated in Lilly's commercial disease areas – neuroscience, endocrinology, and oncology. *See* Sheila M. Rothman, et. al. *Health Advocacy Organizations and the Pharmaceutical Industry: An Analysis of Disclosure Practices*, 101 Am. J. Pub. Health 1854 (2011). Not only were Lilly's grants concentrated in the exact therapeutic areas where its best-selling drugs competed, but the company's own grant policy required that funds be used only for their stated purpose — channeling money specifically toward patient advocacy and consumer education in commercially active disease categories aligning with pharmaceutical industry marketing goals and increased product sales. *Id.*

The pharmaceutical industry purposefully invests resources into HAOs at least in part because the public and policymakers perceive HAOs as independent third-party spokespeople, unlike industry itself. Indeed, pharmaceutical industry public relations materials explicitly acknowledge that advocacy groups deliver credibility that commercial actors cannot. *See* Rothman, *supra* at 603 (Noting that pharmaceutical executives regard funded advocacy groups as entities that can be counted on to speak out in times of need; and that "[a] message's credibility is greater when delivered by impartial third parties than by entities seeking to profit from it.")

Moreover, one of the most consequential documented effects of pharmaceutical funding is what advocacy organizations *do not* say, not merely what they do say to support the pharmaceutical industry. Some organizations are so financially or organizationally compromised that they are structurally incapable of taking positions adverse to the pharmaceutical industry.

This "silencing effect" of pharmaceutical funding represents the clearest direct harm to patients. *See, e.g.*, Michael F. Jacobson, *Lifting the Veil of Secrecy from Industry Funding of Nonprofit Health Organizations*, 11 Int'l J. Occup. & Envtl. Health 349-355 (2005)(Study found that some organizations' freedom to speak out on matters of interest to their funders was actively constrained by the funding relationship — not merely potentially compromised).[11]

Indeed, as explained in more detail below, amici's positions lack credibility not only because of what they affirmatively state concerning vaccines and infectious disease, but also because of their omissions.

B. The Independence of HAOs is Further Compromised by Governance Issues Including Weak Conflict of Interest Policies and the Executive Revolving Door

Financial conflicts of interest are magnified when industry representatives who sit on advocacy organization boards participate directly in decisionmaking concerning research priorities, advocacy positions, policy recommendations, and grant-making, as those decisions may directly affect the commercial interests of their employers or former employers. For example, one review found that 39% of the 104 largest patient advocacy organizations had current or former pharmaceutical, device, or biotechnology industry executives serving on their boards of directors. *See* McCoy, *supra* at 883. It also noted that many of these Industry board members had no personal experience with the diseases the organization addressed, suggesting

[11] *See also* Rose, *supra.*, (HAO executive survey reported that many organizations perceived pressure to conform their positions to the interests of corporate donors or partners); Rothman, *supra.* (Noting concern that HAOs consistently take positions that align with Industry interests even when contradicting goals that would benefit patients); *Shocking Conflicts of Interest in Nonprofit Patient Charities*, People's Pharmacy (Sept. 5, 2023), https://www.peoplespharmacy.com/articles/shocking-conflicts-of-interest-in-nonprofit-patient-charities. (American Heart Association's statin guidelines characterized adverse effects as rare and the perception of side effects as "misguided," contradicting independent evidence, minimizing adverse effects, and discouraging positions that would be therapeutically prudent); Anne M.J. Somers et al., *Pharmaceutical company funding of cancer patient advocacy organizations in the Netherlands*, 41 J. Cancer Pol'y 100493 (2024) (Study documenting Dutch cancer advocacy organizations objecting to stricter drug standards designed to protect patients from ineffective treatments).

their presence was best explained by the pharmaceutical industry's interest in maintaining access and influence. *Id.* Sometimes referred to as the "revolving door" between industry and the nonprofit world, another study found it shocking that, among the 50 highest-revenue HAOs, three-quarters had board members, senior paid staff, or executives with prior or current ties to pharmaceutical and medical device industries, noting broader penetration beyond board level employees. *See* Shamik Bhat, *et al.*, *Medical Product Industry Ties to Patient Advocacy Organizations' Executive Leadership*, 183 JAMA Internal Med. 1224 (2023).

Importantly, these conflicts can persist even after formal employment relationships end. Advocacy organization leadership frequently includes individuals who have spent their careers at pharmaceutical companies, bringing institutional loyalties, professional networks, and potential financial interests (stock, pensions, consulting relationships) that are not erased by a change in employer. This has been characterized as a structural feature of the pharmaceutical industry-nonprofit ecosystem, and many believe that HAOs should adopt more strict conflict of interest policies.[12] These governance issues present a dual conflict, if the organization is both financially dependent on the pharmaceutical industry and administratively guided by industry-affiliated individuals.

C. Pharmaceutical Funded Advocacy Organizations Are Complicit in Agency and Policy Capture

Pharmaceutical-funded advocacy organizations also actively participate in FDA proceedings, advisory boards, congressional testimony, and regulatory comment processes as

[12] *See Patient Advocacy Nonprofits' Dark Ties to Industry,* For Purpose Law Group (FPLG) Insights (May 26, 2017), https://www.fplglaw.com/insights/patient-advocacy-nonprofits-dark-ties-to-industry/; Rothman, *supra* (noted that HAOs had not developed the conflict-of-interest disclosure standards applied to major hospitals, research institutions, and medical journals); Lisa Bero et al., *Caution is prescribed for American Academy of Paediatrics' Guidelines on Weight Loss medications for Childhood Obesity*, BMJ, July 7, 2025, at e084760, https://www.bmj.com/content/390/bmj-2025-084760)(peer-reviewed article noting that author is unaware of any medical society with a good COI policy.)

ostensibly independent or patient-focused voices — without disclosing financial relationships with interested parties. HAOs carry exceptional weight in proceedings before the FDA, Congress, and administrative agencies because regulators and legislators credit them as independent representatives of patient experience. When advocacy organizations substantially funded by the pharmaceutical industry opine or seek approval, the proceeding is arguably compromised — but no mechanism currently exists to require disclosure of the relationship. *See, e.g.*, Rothman, *supra* (The advocacy positions of HAOs on many issues are functionally indistinguishable from pharmaceutical industry lobbying positions); Diedtra Henderson, *Drug Firms' Funding of Advocates Often Escapes Government Scrutiny: Many Patient Groups Depend on It, Raising Tricky Ethical Questions*, Boston Globe. March 18, 2007 http://www.boston.com/business/globe/articles/2007/03/18/drug_firms_funding_of_advocates_often_escapes_government_scrutiny (Boston Globe investigation established that drug company funding of patient advocacy groups often escapes government scrutiny precisely because no regulatory mechanism requires disclosure in regulatory or legislative contexts); Gardiner Harris, *Drug Makers Are Advocacy Group's Biggest Donors, New York Times*.October 22, 2009, at A23 (New York Times reporting documented that drug makers were the dominant category of funder for many major advocacy groups testifying on drug policy before Congress); Rose, *supra.* (Finding HAOs "shape research agendas," influence FDA and health insurer policies, and lobby Congress — making their conflicts of interest a matter of direct institutional integrity).

As shown below, these issues plague leading Petitioners' amici in this case.

II. DOCUMENTED CONFLICTS INVOLVING AMICI CURIAE IN THIS CASE RAISE SIGNIFICANT CONCERNS REGARDING THEIR INDEPENDENCE

While public sources document some of the vaccine manufacturers' massive financial investment in HAOs, there is no legally mandatory disclosure, so the body of information,

especially regarding organizational funding, is necessarily incomplete and effectively shielded from public view. Notwithstanding these barriers, many of these HAOs, including amici in this case, have issued consequential guidelines or positions while their personnel (or the organization) receives financial remuneration from pharmaceutical manufacturers. The effective infiltration by pharmaceutical companies into the public decision-making sphere should not be ignored. With high trust and low transparency, there is an elevated risk that courts and policymakers may rely on incomplete information when evaluating HAO claims. The lack of disclosure calls into question the accuracy of the HAO amici's advocacy submissions.

A. American Academy of Pediatrics is Rife with Conflicts

The AAP is a membership trade organization, protecting its paying members, approximately 67,000 pediatricians[13] and other similar practitioners. As such, AAP's primary advocacy responsibility is to its members. *See* Rothman, supra. at 603 ("Contemporary HAOs advocate almost exclusively for members' special interests.")[14] The interests of children and physicians frequently diverge because AAP's members' revenue depends on the administration of vaccines and well baby visits. *See* James Lyons-Weiler & Paul Thomas, *Vaccine Practice Payment Schedules Create Perverse Incentives for Unnecessary Medical Procedures — at What Cost to Patients?*, 2 Int'l J. Vaccine Theory, Prac. & Rsch. 25 (2021) (significant financial incentives for pediatricians to administer the maximum number of vaccines); *see also* Brenda Baletti, Ph.D.*Vaccines Big Money-Makers for Pediatricians? RFK Jr. Comment During Interview With Tucker Carlson Sparks New Debate* (July 31, 2025),

[13] *See* AAP website, https://www.aap.org/en/membership-application/join-aap/?srsltid=AfmBOoo-HPtrXP4xfjy6nSFIzSsFONHtM6956SP5AKCMZTB9-wVYuwcm

[14] AAP also spends substantial sums lobbying for its members' interests. Over the last three years alone, it has spent $1.8 billion. See https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2025&id=D000046805

https://childrenshealthdefense.org/defender/vaccine-incentives-pediatrician-profits-rfk-jr-tucker-carlson/.

Importantly, AAP also receives an undisclosed amount of direct financial support from four major manufacturers of childhood vaccines — Pfizer, Merck, Moderna, and Sanofi. Although the precise dollar figure is undisclosed, these companies and their brands are prominently featured on the AAP website as "corporate supporters" at the President's Circle level ($50,000 and above annually),[15] as shown in this screenshot from AAP's website:

Further, while we do not know the amount paid to attend, AAP holds an annual "Corporate Summit" for these substantial donors, giving pharmaceutical companies direct access to pediatric policy discussions.

In addition to donations, AAP also receives specific grants from pharmaceutical manufacturers. As an example of Merck's sponsored advocacy, a 2023 Merck grant registry

[15] https://www.aap.org/en/ways-to-give/current-corporate-and-organizational-supporters/

indicates an award for $314,063 specifically to address "*vaccine hesitancy in the private sectors and vaccine confidence committees*." *See* Merck website, https://www.merck.com/wp-content/uploads/sites/124/2024/01/gPRIME-2023_Transparency_Data.pdf. AAP also generates revenue by selling pharmaceutical advertising space in its flagship journal, Pediatrics, giving industry a commercial presence in the AAP's primary scientific publication. *See* Michael Schulson, *A Question of Conflicts at America's Top Pediatrician Association*, Undark (Sept. 4, 2025), https://undark.org/2025/09/04/conflicts-pediatrician-association/. In light of the foregoing, it is not a stretch to question whether AAP has any incentive to question the safety of the vaccine schedule or to support research concerning links between vaccines and the childhood chronic disease epidemic.

AAP was recently the subject of a prominent journal article and an investigative piece about problematic conflicts with pharmaceutical companies, particularly in the realm of clinical treatment guidelines. *See* Bero, *supra*; Schulson, *supra*. The stakes are especially high in guideline development since relatively small groups of physicians and scientists write recommendations that can impact health care across the country. *See* Bero, *supra.* Indeed, treatment guidelines and recommendations often translate to insurance coverage and mandates of pharmaceutical products.[16]

The 2025 investigations found specific instances in which AAP and/or its authors of clinical practice guidelines or AAP-endorsed recommendations failed to disclose consulting fees or research funding from pharmaceutical companies whose products were evaluated in the guidelines. *Id*. Examples include:

[16] For example, California recently adopted AAP vaccination guidelines, incorporating them into mandates for entry into primary school; updated CDC guidelines were rejected. *See, e.g.,* Cal. Health & Safety Code § 1367.002 (West 2025) (as amended by Assem. B. 144, 2025–2026 Leg., ch. 105 (Cal. 2025)).

1) AAP officially recommended prescribing statins to children, lowering the minimum age, after receiving over $1.4 million from statin manufacturers Merck, Abbott, and Bristol Myers Squibb. *See* Richard Gale & Martha Rosenberg, *Why Does the American Academy of Pediatrics Put Corporate Profits Ahead of Children's Health?*, CounterPunch (Dec. 21, 2012) (2012 investigative article discussing why AAP recommendations appear to undermine children, including vaccines, psychiatric drugs, and statins).[17]

2) An author of the 2018 AAP-endorsed guidelines on adolescent depression treatment consulted for the makers of the antidepressants Zoloft and Lexapro but failed to disclose this conflict in the guidelines. *See* Schulson, *supra.*

3) Regarding AAP policy statements and committee work on COVID-19 vaccines for infants and children, public records (Open Payments data) show that at least 9 of 16 members of the committee received financial remuneration from vaccine manufacturers, with five having ties specifically to COVID-19 vaccine makers (Pfizer, Moderna). Schulson, *supra*.

One particularly troubling example of AAP's conflicts involves its development of obesity drug guidelines for children as young as eight. Laura A. Schmidt *et al.*, *Caution is Prescribed for American Academy of Paediatrics' Guidelines on Weight Loss Medications for Childhood Obesity*, BMJ (July 7, 2025), https://www.bmj.com/content/390/bmj-2025-084760. More than one-third of guideline authors had financial relationships with the manufacturers of those medications. Further, manufacturers of GLP-1 receptor agonists had previously contributed an estimated $1.9–$2.6 million in sponsorships to AAP, over a span of years, including during the guideline development period. Not surprisingly, prescriptions of anti-obesity medication for children in the U.S. reportedly rose by 38% in the year following publication of these guidelines. *Id.*; *see also* Schulson, *supra*.

Indeed, AAP provided a consensus recommendation regarding obesity drugs for young children. Knowing there were no published clinical trials for young children, the guidelines nonetheless omit any discussion of risks, harms, treatment duration, or benefit-harm assessment.

[17] https://www.counterpunch.org/2012/12/21/why-does-the-american-academy-of-pediatrics-put-corporate-profits-ahead-of-childrens-health/

Bero, *supra.* AAP's willful blindness regarding the absence of safety science in the GLP-1 scenario is strikingly similar to its willful blindness regarding the absence of safety science on the childhood vaccines at issue in this case, as discussed below.[18] Both point to significant concern regarding industry influence at AAP and among its members and leadership.

In addition to financial conflicts, AAP has been criticized for weak conflict of interest policies, and opaque administration of those policies. *See* Schulson, *supra* ("The AAP's closed deliberations also make it difficult to know the precise nature of consulting relationships between researchers and drugmakers — including whether the work involved a medication that might be indirectly supported by an AAP policy statement, or some unrelated matter.").[19]

In short, even with limited publicly disclosed information, it is clear that AAP has significant financial ties to industry, and its statements should be approached with caution.

B. Infectious Disease Society of America Also Has Substantial Conflicts

Like the AAP, the Infectious Disease Society of America (IDSA) is a member organization whose paying members include scientists and health practitioners specializing in infectious disease. The IDSA is also no stranger to pharmaceutical company conflicts, including that the former Board President, Dr. Tina Tan — who also has ties to AAP — serves on vaccine advisory boards for multiple pharmaceutical companies, including Merck, Sanofi Pasteur, GlaxoSmithKline, and Pfizer/Wyeth. *See* Dr. Tina Tan Professional biography, *supra.*

[18] In fact, the history of the AAP's involvement with childhood vaccines since the 1986 Act is detailed in a RICO lawsuit by certain individuals and CHD against the AAP. *See* Complaint, *Shaw v. American Academy of Pediatrics*, No. 1:26-cv-00171 (D.D.C. filed Jan. 21, 2026).

[19] AAP's prominent leaders also have significant industry ties. For example, Dr. Tina Tan, served in AAP leadership positions, including Chairperson of AAP's Section on Infectious Disease and contributed to the AAP's Red Book (which AAP cites as authority in this case), while at the same time serving on vaccine advisory boards for multiple pharmaceutical companies, including Merck, Sanofi Pasteur, GlaxoSmithKline, and Pfizer/Wyeth. *See* Dr. Tina Tan Professional biography, https://www.waidid.org/site/boardmember/10.

IDSA's conflicts regarding clinical practice guidelines were recently featured in a cross-sectional study, which assessed IDSA clinical practice guideline authors from 2017–2022 and found widespread conflicts of interest between the authors and pharmaceutical companies that manufacture the drugs recommended in those same guidelines. *See* Aileen S. Ahiskali, et al., *Conflicts of Interest Among Infectious Diseases Clinical Practice Guideline Authors and the Pharmaceutical Industry*, 6 JAMA Network Open e238592 (2023). These guidelines included COVID-19 treatment, influenza, and antimicrobial resistance.

The study also assessed compliance with both the Institute of Medicine guidelines and Council on Medical Specialty Societies principles for managing conflicts of interest in guideline development and found meaningful gaps. For example, among the thirty-seven IDSA clinical practice guidelines analyzed, the COVID-19 guideline was specifically examined. Guideline authors had disclosed relationships with companies of antivirals recommended in the guidance. *Id.* Overall, this study found that 48% of authors across ten IDSA guidelines had pharmaceutical industry ties, with 32% linked to recommended drugs; as well, multiple guidelines failed Institute of Medicine/Council of Specialty Societies standards on panel composition. *Id.*

The IDSA was also investigated by the Connecticut Attorney General for antitrust violations regarding financial conflicts with certain insurance companies after IDSA's Lyme disease treatment guidelines, released in 2006, drastically limited treatment options. *See* Raphael B. Stricker & Lorraine Johnson, *Lyme Disease: The Next Decade*, 4 Infect. Drug Resist. 1 (2011). The investigation found significant conflicts of interest and suppression of data in the guidelines development process. Although IDSA agreed to create a new scientific panel to review these guidelines, which "considered" significant evidence of persistent infection despite short-course therapy (which was previously denied), the IDSA voted unanimously to uphold its

prior guidelines. Sadly, this result was not surprising given that seven of the eight members of the review panel were members of IDSA, which selected the panel. *Id.*

In sum, as with AAP, IDSA's claims should be thoroughly vetted before accepting them at face value.

C. American Public Health Association and American College of Physicians

Like the AAP and IDSA, the American Public Health Association ("APHA") and the American College of Physicians ("ACP") are membership organizations whose paying members are health professionals. While less is known about the financial structure of these organizations, at least one study found that ACP failed to disclose financial conflicts with pharmaceutical companies. *See* Maryam Mooghali et al., *Financial conflicts of interest among US physician authors of 2020 clinical practice guidelines: a cross-sectional study*, BMJ Open 2023;13**:**e069115. doi: 10.1136/bmjopen-2022-069115 (Study found 37.4% of authors disclosed pharmaceutical industry ties via self-report, but Open Payments data showed widespread under-reporting; 73.7% had actually received undisclosed payments, including the ACP). Likewise, the APHA website indicates APHA receives a substantial portion of its revenue (approximately 31% in recent budgets) from contracts, grants, and corporate sponsorships. This includes funding from pharmaceutical companies, biomedical device manufacturers, and other commercial entities, particularly for the APHA Annual Meeting & Expo (a major revenue source through exhibitor fees and sponsorships).

D. Other Amici Organizations

Additional amici with documented ties to the pharmaceutical industry include the Alliance for Aging Network (AFAR) and Network for Public Health Law (NPHL). Regarding AFAR, not much is known about its funding, but it presents a strong example of pharmaceutical governance

capture in current advocacy. A May 2025 report by Patients for Affordable Drugs found that 15 of AFAR's 20 board members have direct ties to pharmaceutical companies, including Pfizer and Johnson & Johnson. The board chair is a pharmaceutical public relations executive; the treasurer is a former pharmaceutical company lobbyist; and multiple board members are investment bankers specializing in pharmaceutical companies. *See* Patients for Affordable Drugs, *The Rampant Reach of Pharma's Hidden Hand* (May 2025), https://www.patientsforaffordabledrugs.org/wp-content/uploads/2025/05/Hidden-Hand-2025.pdf.

Lastly, Defend Public Health ("DPH") was newly created in 2025. Although not much is known about this new organization, a recent article chronicles actions taken jointly by an association of advocacy groups, including DPH, to attempt to oust the current Secretary of Health and Human Services, given his intention to further research risks associated with the vaccine schedule and make changes if necessary. *See* Sayer Ji, *A Look at Who's Behind the Escalating Fake 'Grassroots' Campaign to Take Down RFK,* The Defender (Oct. 27, 2025), https://childrenshealthdefense.org/defender/look-behind-escalating-fake-grassroots-campaign-take-down-rfk-jr/. Notably, DPH functions as a philanthropic intermediary, which accepts donations through the Peace Development Fund (PDF). This structure allows tax-deductible donations to flow from anonymous donors through PDF to DPH. *See* DPH website, https://www.defendpublichealth.org/about-us. Although the opacity of DPH's funding is concerning, no Industry connections can be confirmed due to the funding structure.[20]

[20] Though not a traditional HAO, amici Network for Public Health Law (NPHL) is a legal organization that produces articles and research advocating, *inter alia*, for more government control over healthcare. *See* Influence Watch website, https://www.influencewatch.org/non-profit/network-for-public-health-law-nphl/. NPHL is a project of the Robert Wood Johnson Foundation, which was founded with a large bequest of pharmaceutical company Johnson & Johnson's stock (143 million shares representing over 90% of the Foundation's assets initially). Though the J&J stock may have been divested over time, its roots and its advocacy are solidly pharma-aligned.

III. AMICI HEALTH ADVOCATE ORGANIZATIONS OMIT CRITICAL INFORMATION REGARDING THE HISTORY AND SAFETY OF VACCINES

While amici (and Petitioners) contend that prohibiting religious exemptions in West Virginia schools is the least restrictive means to secure children's health and public health, the fact that 46 other states currently permit religious and/or personal belief exemptions without a rise in mortality while maintaining high vaccination percentages starkly undermines it.[21] Indeed, many state legislatures are considering complete removal of such mandates, and one state has already done so. *See* Idaho Medical Freedom Act, Idaho Code § 73-501, *et seq.* (2025). Moreover, many countries in the world, including sixteen European countries, most of Canada, Japan, South Korea, India, New Zealand, China, and Russia have no mandates while still maintaining high vaccine coverage percentages. *See* World Population Review, *Vaccine Mandates by Country 2026*, https://worldpopulationreview.com/country-rankings/vaccine-mandates-by-country (last visited May 5, 2026) (noting these countries rely upon strong recommendations rather than mandates, yet maintain high vaccination rates through healthcare access and public trust); *see also* ASSET reports, *Compulsory Vaccination and Rates of Coverage Immunisation in Europe*, (Jan. 2016), https://www.asset-scienceinsociety.eu/reports/page1.html (Comparison of coverage rates of immunization against polio, measles, and pertussis-containing vaccines in European countries from 2006-2013 found no relationship between mandating vaccinations and increased rates of childhood immunization).

[21] *See* Nat'l Conf. of State Legislatures, State Non-Medical Exemptions from School Immunization Requirements, https://www.ncsl.org/health/state-non-medical-exemptions-from-school-immunization-requirements (updated May 1, 2026).

It is hard to believe that China and Russia permit their citizens more religious freedom than West Virginia purports to extend.

Appellants and their amici curiae mislead and overstate the alleged public health threat a religious exemption would create and the safety and efficacy of the vaccines mandated for West Virginia's children. Importantly, the amici curiae fail to inform the Court of a critical and *undisputed* void in the safety science surrounding vaccines and the vaccine schedule.

Specifically, before the 1986 Act was passed *due to injuries and litigation and a threat by manufacturers to stop making vaccines*, the childhood vaccine schedule consisted of 11 doses targeting four diseases (as of 1983); however, it exploded over the subsequent years and is currently 72 doses. [22] As the schedule grew, parents expressed concern about cumulative effects. By the early 2000s, even an AAP survey showed 23% of parents questioned the number of shots their children received, and 25% worried vaccines might weaken the immune system.[23] Simultaneously, chronic illness rates in children rose dramatically - studies show that approximately half of American children have at least one chronic illness. *See, e.g.*, MAHA Report, *supra* at 9-19 (documenting rise in chronic childhood disease). Yet, neither the pharmaceutical companies nor amici HAOs, which claim to be children's health advocates, have been interested in whether the aggressive vaccination program they recommend contributes to this assault on children's health.

In 2002, however, the Institute of Medicine issued its first report on cumulative vaccine schedule safety. *See* Institute of Medicine, *Immunization Safety Review: Multiple Immunizations*

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[22] Compare CDC 1983 Schedule, https://www.cdc.gov/vaccines/schedules/images/schedule1983s.jpg (1983) and CDC 2025 Schedule https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/child/0-18yrs-child-combined-schedule.pdf (2025).

[23] *See* Bruce G. Gellin, et al., *Do Parents Understand Immunizations? A National Telephone Survey*, 106 Pediatrics 1097 (2000), https://publications.aap.org/pediatrics/article-abstract/106/5/1097/63219/Do-Parents-Understand-Immunizations-A-National?redirectedFrom=fulltext

and Immune Dysfunction (National Academies Press 2002) ("IOM 2002"). The IOM found in no uncertain terms: "there is no study that compares an unvaccinated control group with children exposed to the complete immunization schedule, nor are there any studies that looked at health outcomes other than those classically defined, such as infections, allergy, or diabetes." IOM 2002 at 36. The IOM added: "the committee recognizes with some discomfort that this report addresses only part of the overall set of concerns of some who are most wary about the safety of childhood vaccines." IOM 2002, Executive Summary.

The IOM recommended "exploring the feasibility of using existing vaccine surveillance systems," naming the Vaccine Safety Datalink specifically, to study "safety questions related to" the immunization schedule as a whole. IOM 2002 at 14–15. The VSD already contained health records for millions of children. The data existed. Eleven years later, with safety of the cumulative schedule still an open question, the IOM returned to the question. It issued a second report in 2013. *See* Institute of Medicine, *The Childhood Immunization Schedule and Safety: Stakeholder Concerns, Scientific Evidence, and Future Studies* (National Academies Press 2013)("IOM 2013"). Note that "Future Studies" appears in the title because the 2002 IOM recommended studies had never been conducted. Indeed, the IOM confirmed: "studies designed to examine the long-term effects of the cumulative number of vaccines or other aspects of the immunization schedule *have not been conducted*." IOM 2013 at 6 (emphasis added).

The IOM identified four research questions that remained unanswered, starting with: "How do child health outcomes compare between those who receive no vaccinations and those who receive the full currently recommended immunization schedule?" IOM 2013, Box S-2. No study had answered that question in 2002. No study had answered it in 2013. Tellingly, none of the pharmaceutical companies or HAOs advocated for this research or sought to facilitate it,

despite data and the potential harm to children's health from unknown and long-term risks. They also failed to inform health care professionals of this significant research gap. Indeed, as indicated above, the HAOs are incentivized to be silent.[24] Nowhere is this more telling than with the epidemic of autism spectrum disorders.

Four amici, including the AAP, IDSA, APHA, and ACP, recently publicized a joint "consensus" statement along with other similar organizations, regarding the link between vaccines and autism, declaring "[v]accines are not linked to autism." *See Statement from Leading Medical, Health and Patient Advocacy Groups on CDC Autism Website Changes* https://www.aap.org/en/news-room/news-releases/aap/2025/statement-from-leading-medical-health-and-patient-advocacy-groups-on-cdc-autism-website-changes/ Their joint statement chastised the CDC for revising its website to inform the public that the absence of scientific studies was not a sufficient basis to conclude that "vaccines are not linked to autism." Indeed, the absence of any link is irrelevant if the scientific studies were never done in the first place. Given that these HAOs claim to advocate for public health and children's health, their failure to encourage scientific inquiry on this issue impacting so many children and families is deafening. Moreover, the continuous mantra of vaccine safety that is communicated to member physicians intentionally keeps them in the dark. Given the incentives involved, it is no surprise that amici HAOs' silence also mirrors the silence of vaccine manufacturers. Amici's statement disavowing

[24] In addition to the absence of studies regarding the comprehensive schedule, the individual vaccines were also never properly studied for risk through appropriate clinical trials. Though the HAOs may maintain otherwise, at least two books have been written meticulously detailing how each vaccine was never tested against inert placebo (but rather other bioactive products, including other vaccines), before approval, and also demonstrating that most of the trials were too small in sample size and too short to determine long-term health effects, including immune dysregulation. *See* Suzanne Humphries & Roman Bystrianyk, *Dissolving Illusions: Disease, Vaccines, and the Forgotten History* (CreateSpace Independent Publishing Platform 2013); *Turtles All the Way Down: Vaccine Science and Myth* (Zoey O'Toole & Mary Holland eds., The Turtles Team 2022); *see also* Informed Consent Action Network, *Vaccine Trials Summary Char*t, (October 18, 2023), https://icandecide.org/article/childhood-vaccine-trials-summary-chart/ (Chart reflecting, *inter alia,* each approved vaccine, the package insert link, results of the trial, how the trial was conducted, and the number of doses on the schedule).

any link between vaccines and autism is patently misleading, arguably a product of its industry ties, and, therefore, the Court should take HAOs' conflicts into account in weighing their position on this issue, particularly where religious freedom, a fundamental right, is threatened.

CONCLUSION

In closing, CHD respectfully requests that the Court consider the Petitioners' amici curiae's significant conflicts of interest with the pharmaceutical industry, which color both what they state and, and, importantly, also what they fail to disclose. Due in large part to these conflicts, including extensive financial conflicts, these amici have overstated the impact of religious exemptions on public health, failed to recognize that less restrictive means exist to control any disease outbreak without imposing unconstitutional restrictions on religious and parental rights, and failed to acknowledge the research gaps concerning vaccine safety and efficacy, which undermine their public health claims. Indeed, religious exemptions are an effectively tailored means to preserve children's and public health, while ensuring the compelling interest in preserving the religious freedom of West Virginians.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I, Morgan M. Switzer, *Esq*., hereby certify that, on the 11th day of April, 2026, I served a copy of the foregoing on each party to this action via File&ServeXpress.

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