Mandatory vaccination and democratic rights: An interview with law professor Dorit Reiss

Benjamin Mateus
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Dorit Rubinstein Reiss is a Professor of Law at UC Law San Francisco (formerly UC Hastings), a member of the Parent Advisory Board of Voices for Vaccines, and a member of the Vaccines Working Group on Ethics and Policy. She writes extensively on the social and legal dimensions of vaccination in law reviews and for public-facing outlets on medicine, policy and the law. She teaches torts, administrative law and public health law.

One of the main issues she focuses on in her scholarship is the legality and necessity of school vaccine mandates. Drawing on more than a century of jurisprudence (including Jacobson v. Massachusetts *and* Zucht v. King*), Reiss explains why courts routinely sustain school-entry requirements: they rest on state police powers, reasonable limits on individual liberty and child protection. In work such as "Litigating Alternative Facts," she shows why First Amendment, parental-rights, and right-to-education arguments against mandates fail.*

Reiss also spends considerable effort debunking misinformation, including the false vaccine-autism narrative. She has analyzed and rebutted high-profile claims and shown how anti-vaccine networks mischaracterize government proposals arguing that agencies must pre-empt distortion with clearer, faster public communication. She clarifies legal terms often weaponized in these debates (i.e., "unavoidably unsafe" does not mean "especially dangerous") and returns repeatedly to the public-health logic of herd immunity.

Professor Reiss accepted the invitation for this interview that places her analysis in today's public-health context and what is at stake for families if those legal and institutional guard rails fail.

Benjamin Mateus (BM): Good morning, Professor Reiss. Thank you for taking the interview. Maybe we can begin with you introducing yourself and how you became involved in vaccines and public health?

Dorit Reiss (DR): I'm Dorit Reiss, a professor of law at UC Law San Francisco—what used to be UC Hastings. I'm also a mom of two, who I think are still asleep. I came to vaccines first as a parent. My PhD was on agency accountability in telecommunications and electricity—nothing to do with health. But when my older son was two, I did what academics do: I learned about parenting by reading books, science blogs. I stumbled on an anti-vaccine comment and was surprised. So, I read more and concluded pro-vaccine parents needed to speak up online. I started there—responding to anti-vaccine claims—then began writing professionally. Now all my research and teaching are about vaccines: school immunization and the law, tort liability, administrative law, and I've written more sociologically about the anti-vaccine movement.

BM: We'll come back to those points. I want to anchor our interview in what's happening now. Robert F. Kennedy Jr. is leading the Department of Health and Human Services, and there have been dramatic changes—not for the better—at the Advisory Committee on Immunization Practices (ACIP), the Centers for Disease Control, and the National Institutes of Health. How should we understand the current moment in U.S. public health? What's actually changing, and what are the legal and policy implications?

DR: A lot is changing. Mr. Kennedy has been committed to anti-vaccine causes for over 20 years. He's a true believer in the idea that vaccines are bad—and he's willing to advance that cause. He arrived with a list of changes and within a broader deregulatory push—essentially, an effort to overhaul the administrative state. Those two things are working together.

One of the first steps was cutting agency staff by more than 20,000—mostly firings, some resignations—and abolishing a long list of programs. The broader pattern is paring down public-health agencies and bringing in political appointees judged more by loyalty than expertise. That isn't just ACIP; it's across the board.

Practically, that means fewer experts inside and more loyalty tests. You're expected to do what leadership wants and here it means aligning with Kennedy's anti-vaccine agenda rather than following the data. Public health is always political to some degree, but historically FDA and CDC leadership, under both parties, gave scientists room, because obviously anti-evidence decisions backfire. That's no longer the norm. Kennedy has clear views and agencies are being steered to align with them. The result: (a) weakened public-health performance—this is ideology over evidence—and (b) damaged trust. I don't know how easily we rebuild trust in FDA and CDC after seeing how quickly a determined political leader can gut them and yoke them to an agenda.

Community rights and individual rights

BM: Given the surge in vaccine skepticism, building now for decades but supercharged during COVID, plus the growing "medical freedom" rhetoric, what are the hardest challenges in balancing individual rights with the community's right not to be exposed to disease? And how have appeals to American individualism and libertarianism, including RFK Jr.'s role in COVID-era misinformation, shaped this debate?

DR: That's a great question, and I'd answer it in three parts.

First, none of this started with COVID. Opposition to vaccination is as old as vaccination and appeals to "liberty" have been there from the beginning. We've gone through cycles like this since the late eighteenth century. We're in another upswing now. Although COVID-19 accelerated it, but it's not the first.

Second, there's the "freedom" frame. Historically, anti-vaccine activism in the United States wasn't neatly partisan. You saw it at the

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ends of the spectrum on both left and right. On the right, distrust of government; on parts of the left, distrust of corporations and a romantic idea of "natural" health. Those impulses are understandable in moderation. The problem is when they're taken to extremes. Over time, especially in the 2010s and around the school-mandate fights after 2015, you saw more partisan sorting. Generally, there was more Democratic support for mandates and more Republican opposition, with exceptions. Then QAnon gained momentum. Its conspiracy logic mapped naturally onto anti-vaccine narratives, so the movements fed each other; people who entered QAnon often adopted anti-vaccine claims, and vice versa.

Third, COVID turbocharged all of this. In a fast-moving pandemic, public-health agencies will make some mistakes, and those were amplified in an information ecosystem where certain outlets, with Fox News preeminent among them, regularly downplayed the pandemic and vaccines. People trust their *trusted* sources; if those sources turn skeptical, audiences follow. You end up with identity-driven views: "vaccines were oversold," "the pandemic was exaggerated," and that spills over to other vaccines. I don't want to overstate it—most U.S. parents still vaccinate their kids and don't want childhood vaccines removed—but Kennedy is building on COVID skepticism. He's been anti-vaccine for a long time, and he's using COVID as a wedge to advance policies that undermine childhood vaccination more broadly.

BM: I want to raise an analogy. A car is designed by a corporation to make a profit. We still trust cars and though sometimes there are defects we regulate and use them because we need them. In the same sense, the fact that *vaccines* are made by corporations shouldn't, by itself, nullify their safety. A company can't succeed with a vaccine that doesn't work. And with COVID, mRNA technology had been studied for roughly 20 years. Does that framing make sense to you?

DR: It does—and it's useful in two directions. First, we already trust many corporate products and cars and airplanes are good examples because we regulate them. The same logic applies to vaccines. Companies have strong incentives to make products at least *reasonably safe*: catastrophic failures are discovered, invite lawsuits, and can send executives to prison. Many people in pharma also choose that work to help patients, even as the firms pursue profit.

Second, governance matters. Corporations exist to make money and without oversight, we should be very concerned. The vaccine oversight apparatus is extensive. There are pre-licensure trials, FDA review, post-market surveillance, manufacturing inspections; and it's not confined to the United States. These vaccines are used across national health systems worldwide. The idea that "pharma controls the government and the media" assumes a level of coordination and competence I've never seen in any large institution. Even if a company somehow captured a U.S. regulator, it couldn't also control independent scientists and foreign health authorities. If something were seriously wrong, it would surface.

On COVID specifically, everyone, including the companies, was living through a real emergency. The world demanded vaccines; these firms stepped up. Of course, they expected profits—that's how private firms operate—but profit-seeking does not erase public need or make the products unsafe. And, as you noted, mRNA platforms had a long research runway before 2020. If you believe in markets at all, when a company makes a vaccine that saves lives, it's not scandalous that they earn revenue from it. The key is accountability and transparency, which is why we keep the regulatory guardrails tight, or we should.

"Informed consent" and vaccine mandates

BM: Another critical question for our discussion: how do "coercion" and "informed consent" work in law and medical ethics? How do they apply to school or workplace vaccine mandates?

DR: Let me start with informed consent, then move to coercion.

Since the early 20th century, US law and medical ethics have increasingly centered on patient autonomy, the right to control what happens to one's body. Historically, medicine was patronizing. You went to the doctor and did what the doctor said. Today, the clinician must explain risks, benefits, and alternatives; the patient decides. The doctrine grew out of cases (I teach them in torts) where doctors ignored patient instructions and the courts in turn said that's unacceptable.

In clinical care, informed consent belongs to adults with decision-making capacity: the clinician discloses risks, benefits, and alternatives; the patient understands and voluntarily decides. There are special rules for people who don't fit that category. For *children*, consent comes from a parent or legal guardian, and we often seek the child's assent when developmentally appropriate. For adults who lack capacity—because of illness or disability—we use a surrogate decision-maker (or an advanced directive if one exists). And for incarcerated people, the law is especially alert to coercion and undue influence. Their dependency on the institution means extra safeguards and limits, particularly around research participation.

On the research side, consent standards are even stricter. There are independent review boards, special protections for vulnerable groups, and a definite line between care and experimentation. That system was built after notorious abuses, including Tuskegee *[the U.S. Public Health Service's syphilis study on Black men, 1932–72, in which participants were deceived and denied effective treatment; a scandal that helped spur modern research-ethics rules]*. One confusion created by the anti-vaccine and anti-public health layers during COVID was treating authorized or licensed vaccination in clinical practice as if it were human-subjects research, which it isn't.

Public health is different because it addresses shared risks. We routinely limit individual autonomy to protect others: drive on one side of the road, don't smoke on airplanes, etc. There are medical analogs, too. People with infectious tuberculosis can be required to complete long antibiotic courses or face liberty restrictions. Courts can order treatment for minors in specific circumstances. The principle is balance; a respect for autonomy but prevent harm to others.

That balance is why *school and workplace vaccination* policies are lawful. Schools are shared spaces, and unvaccinated attendance raises risks for classmates, infants too young to vaccinate, immunocompromised students, and staff. Parents have broad authority over their children, but not to expose other people's children or their own to communicable disease. Courts have upheld school-entry rules on that basis for a century.

Finally, *coercion* in law means an improper threat that leaves no reasonable alternative. It's different from pressure or inconvenience, and different again from undue influence (e.g., an outsized payment to a research subject). A neutral, evidence-based condition of participation such as school entry or certain jobs paired with accommodation and, at most, exclusion or modest penalties, is *not* coercion. It's the standard way we balance private choice with public risk, while keeping oversight in place: courts for constitutional review, political checks, transparency, and time-limited measures so compulsion isn't open-ended.

False claims of "coercion" and violations of "medical freedoms"

BM: Libertarians and "medical freedoms" advocates claim school vaccine mandates are coercive. But how does the law view that?

DR: Fair to ask, but it's worth noting that not all libertarians advocate

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for "medical freedoms." Some accept school mandates on a classic *harm-to-others* theory: your liberty ends where you endanger someone else's child.

Legally, the view runs the other way from "coercion," for two main reasons.

First, children's welfare (*parens patriae*). School mandates regulate parents' choices about children. Kids aren't refusing on their own; adults are declining on their behalf. We protect parental rights, but they're not absolute. The state already sets limits to prevent harm; child-labor laws, compulsory education, and medical-neglect rules are basic examples. Routine childhood vaccines have benefits that vastly outweigh their small risks, so requiring them is understood as protecting the child.

Second, public health in shared spaces. Schools have *shared air*. Unvaccinated attendance increases risk to classmates, infants too young to vaccinate, immunocompromised students, and staff. It's not just your child; it's everyone they breathe with. A friend once picked up her five-year-old with a three-week-old in tow only to learn the kindergarten had a chickenpox outbreak. That baby was too young to vaccinate. This is why the law treats schools as settings where preventing externalities—your choice imposing risk on others—is legitimate.

Because school mandates sit at the intersection of children's rights and community protection, courts have upheld them for a century. They're typically structured as conditions of attendance (with medical exemptions), not forced injections, which also matters for the "coercion" claim.

One complication today, however, is that the courts have become more aggressive about protecting religious exercise. Some states that had tightened exemptions are being pushed to restore or expand religious exemptions. Those exemptions are difficult to police and can undermine herd protection. But the core rule remains: school-entry vaccination requirements themselves rest on very strong legal ground, precisely because they protect children and the broader school community.

BM: Does "coercion" in law imply causing harm or removing real choice? Given that vaccines confer benefits to the recipient and others, how should we understand that term here?

DR: Legally, coercion means an improper threat that leaves no real alternative. A neutral, evidence-based condition of school attendance—with medical exemptions and, at most, exclusion or modest penalties—doesn't meet that standard. But I'd qualify the discussion in two ways.

First, nothing effective is risk-free. Vaccines can cause rare adverse events. Anaphylaxis, for example, is on the order of about one per million doses. So, anyone promising "zero risk" isn't being candid. The point is comparative risk: those vaccine risks are *far smaller* than the risks from the diseases they prevent.

Second, many parents who decline vaccines overestimate those risks because they've been exposed to *disinformation*. They're not seeing the same evidence you and I are, so they interpret "mandate" through a fear lens. Clear communication about real, but very small, vaccine risks, and the much larger disease risks, helps put the term "coercion" in proper legal and ethical context.

BM: Understood—and historically the disease burden faced by populations over generations makes that comparison clear which brings me to the legal foundations. Looking back at *Jacobson v. Massachusetts* (1905) and *Zucht v. King*(1922), which established state authority to require vaccination and school entry rules, and considering that *Lochner v. New York* (1905) wasn't a vaccine case but reflected the era's skepticism toward regulation often aligned with business interests, did that mindset shape modern fights over COVID measures? How have those rulings guided or complicated today's controversies?

DR: It's an interesting question. You're right that *Jacobson* was decided in what we shorthand as the Lochner era, when the Court was very aggressive about protecting economic liberty and struck down several workplace-protection laws (like maximum-hours rules) in the name of freedom of contract. Even in that climate, the Court in *Jacobson* upheld a vaccination requirement as a valid exercise of the state's "police power" for public health. The message was: liberty matters, but *public health can justify reasonable limits*.

Two clarifications about *Jacobson*. First, it endorsed reasonable limits, not anything-goes. Cambridge, Massachusetts had a smallpox outbreak with deaths. The local board of health (under a longstanding state statute) required vaccination for anyone not vaccinated within the last five years. Henning Jacobson refused. Part of his objection was skepticism; he argued the vaccine was dangerous and ineffective. The other aspect was constitutional that the mandate violated his *liberty*. The Court responded by stating that liberty is not absolute—if everyone sets their own rules, society can't function. They also acknowledged that the state may impose reasonable public-health measures. And on the contested medical questions, courts generally defer to policymakers when the weight of medical opinion supports the measure.

Second, that deference cuts both ways. In principle, if a policymaker hostile to vaccines heads a public-health agency, *Jacobson*'s framework still gives some leeway to policy choices though modern administrative law scrutinizes agency reasoning more closely than in 1905. It's a mixed picture: we look to courts to protect against abuse or arbitrariness, but judges aren't scientists and can get it wrong as easily as right. So, the through-line from *Jacobson* is not blind acceptance; it is deference bounded by reasonableness. Public-health measures must have a real, evidence-based relation to protecting health, and courts remain a backstop against overreach.

Public health and business interests

BM: On the *Lochner v. New York* (1905) case where Justice Harlan's dissent tracks his approach in *Jacobson*, it seems the contradictions posed by public health needs and economic interests were evident then. On one side of the argument is keeping workers healthy and on the other when such measures cut into profits and business resist. In effect, they want the benefits of a healthy workforce but without the constraints of public-health rules. Is that the tension?

DR: That's the tension, and it's largely short-term vs. long-term.

Over the medium and long term, disease is expensive. There is lost productivity, disrupted supply chains, and high turnover. If half your workforce is sick, your business doesn't function. So, employers have a real stake in effective public health.

In the short term, specific measures such as temporary closures, retooling operations, buying protective equipment, offering paid sick leave can feel costly. The U.S. labor system also encourages *presenteeism*: many workers are penalized for staying home sick, which is bad for public health but can look cheaper in the short run on a balance sheet.

So, you get an apparent dual posture. Sometimes business supports strong measures (because the alternative is shutdowns or outbreaks). For instance, early in the COVID pandemic, I found myself talking with chambers of commerce around the country about workplace vaccine mandates because many saw them as the path to staying open. In other contexts, firms resist. The short-term math is vexing. They balk at costly PPE, paid sick time, or investments in ventilation upgrades, even though sick or injured workers are bad for their business.

The bottom line is that businesses often want the *outcomes* of public health (healthy, reliable labor) but not the *inputs* when they cut into their profits. Public policy exists to solve that mismatch—pricing externalities and setting baseline rules so the long-term interest isn't sacrificed for

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short-term gain.

BM: Quick question on *Zucht v. King*. Could you speak to it briefly—what the case held and how it shaped school vaccination rules?

DR: *Zucht v. King* was short but important. It came out of San Antonio, Texas, where the city required proof of vaccination for public and private school attendance—even though there wasn't an active smallpox outbreak. A parent sued after her unvaccinated child was denied entry.

Justice Brandeis, writing for the Supreme Court in 1922, essentially said: this is constitutional—see *Jacobson*. The Court held that (1) school vaccination rules can be *preventive*, not just emergency measures; and (2) exclusion from school is a lawful consequence. That's a key shift from *Jacobson*, which involved a modest fine; *Zucht* confirms that communities may protect schools by conditioning attendance on vaccination.

Parents often experience exclusion as coercive, and some states once piled on truancy penalties, but constitutionally the principle is clear: to guard against communicable disease in a shared setting, a city can require vaccination for school entry—without waiting for an outbreak and without granting officials arbitrary power.

BM: Kennedy and his allies say they want to "revamp" the National Childhood Vaccine Injury Act of 1986. For readers new to this, can you explain why Congress created the Act, how the Vaccine Injury Compensation Program (VICP) works, and what it has meant for vaccine safety, supply, and public trust since its enactment? And if the program is weakened or dismantled, what would that mean for access, prices, liability exposure, and school and workplace requirements? Congressman Paul Gosar of Arizona has introduced a bill that would upend this landmark legislation. [*In July 2025, Rep. Paul Gosar (R-AZ) introduced the "End the Vaccine Carveout Act," a House bill that would allow plaintiffs to sue vaccine manufacturers directly rather than first filing in VICP, effectively unwinding key liability protections of the 1986 Act; it is pending in committee.*]

DR: In the 1980s there was a surge of litigation over the DTP vaccine. Most plaintiffs lost, but the volume and cost of suits were high enough that manufacturers began leaving the market. Routine childhood vaccines are steady but not high-margin products; litigation costs eat into those margins. Within a few years, the number of DTP makers dropped from roughly 18 to five, then three; eventually only two remained, and they were considering exiting. Congress worried the U.S. could be left without vaccines for diphtheria, tetanus, and pertussis.

So, stakeholders struck a compromise that became the National Childhood Vaccine Injury Act of 1986. Beyond compensation, the Act improved informed consent by creating the federal Vaccine Information Statement (VIS) that must be given before vaccination; it's short, clear, and standardized. It also created VAERS (the Vaccine Adverse Event Reporting System), a public system where anyone can report a suspected post-vaccination event, part of broader safety surveillance.

The role of the Vaccine Injury Compensation Program (VICP)

The Act also created the Vaccine Injury Compensation Program (VICP), a no-fault system. In civil court, an injured person must prove the product was defective (design, manufacturing, or warning) and that it caused the injury. In VICP you don't have to prove defect—only causation and damages—under a claimant-friendly preponderance standard, with relaxed evidentiary rules. The program also pays attorneys' fees and costs separately (if the claim was filed in good faith), so awards aren't reduced by contingency fees.

There are limits. The Act channels most claims into VICP first; after a decision or 240 days without one, a petitioner can exit to court. But the Supreme Court has held that design-defect claims for covered vaccines are preempted; you can still sue later for negligence, manufacturing defect, fraud, or certain failure-to-warn theories, but not "the design was too dangerous." So, manufacturers and vaccinators have limited—not absolute—liability protection.

This doesn't mean manufacturers never face court cases. For example, there have been hundreds of lawsuits against Merck over the HPV (Gardasil) vaccine in general courts after VICP filings. Those cases have faced setbacks at the trial-court level and are on appeal, but they illustrate that civil litigation still happens; VICP is the first stop, not the only possible forum. Most plaintiffs' attorneys will tell you that if a claim can't meet VICP's easier standard, it's unlikely to succeed in civil court.

What's new are the efforts to blow up the channeling. Rep. Paul Gosar (R-AZ) has introduced a bill to remove key liability protections—allowing people to sue directly in state or federal court without first going through VICP and even filing claims without time limits. That is unusual in tort law, which typically has two or three-year statutes of limitations to preserve evidence and finality. Open-ended liability and a return to forum-shopping would likely trigger a wave of suits, raise costs, and push manufacturers to exit the pediatric vaccine market—precisely the crisis the 1986 Act was designed to avoid.

As for the current administration, it has signaled an intent to "reform" VICP but has been non-specific and has often skipped the usual notice-and-comment transparency. Given the anti-vaccine record of key figures, there's reason to worry about changes that undermine the program. If VICP is weakened or dismantled, expect reduced supply, higher prices, and access problems; school and workplace requirements also become unenforceable if families can't reliably get the vaccines.

BM: I think the long-term consequences are stark. By my count, there are roughly 250 vaccine manufacturers globally, and more than half are in the United States. If liability protections are stripped, it could chill production, never mind the knock-on effects on school requirements and mandates.

DR: When litigation risk spikes, the rational move for many companies is to step away from low-margin, high-scrutiny products and make something more profitable. If enough manufacturers exit, you get shortages and fragile supply, and then even willing families can't get vaccinated. At that point, school and workplace requirements become unenforceable in practice because access isn't reliable.

BM: Next week ACIP meets under a roster reshaped by Kennedy—after replacing the CDC director and seating several appointees with little vaccine expertise but strong anti-mandate views. What should the public expect from this meeting, and what are the real downstream consequences of whatever ACIP votes?

DR: As of now, the roster shows seven new members, with reports that seven more are still being vetted. Given the pattern of doing things by fiat, it's unclear whether additional members will be added right before the meeting or whether the committee proceeds with the seven already seated.

Most of these appointees were clearly chosen for hostility to COVID-19 vaccination, and some are skeptical of other vaccines as well. They generally lack deep vaccine expertise. The notable exception is Dr. Cody Meissner, a respected pediatric infectious-disease specialist and former ACIP member, who has voiced skepticism about certain COVID policies; that likely influenced his selection. The rest may have expertise in other areas, but *vaccines aren't their field*.

Substantively, I'm concerned they will try to withdraw or narrow recommendations on COVID-19. To be clear, ACIP recommendations do not "pull" a vaccine from the market—that's FDA's job, and FDA licensure remains. But ACIP drives *access* in three critical places:

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1. Medicaid generally covers ACIP-recommended vaccines. Remove a recommendation and Medicaid coverage can vanish.

2. Vaccine for Children (VFC), which covers roughly half of U.S. children, depends on ACIP recommendations; lose the recommendation and many children lose no-cost access.

3. Under the ACA, private plans are required to cover ACIP-recommended vaccines with no cost-sharing. If ACIP backs away, some insurers may still cover them on their own because prevention is cheaper than hospitalization, but others won't. The result shows up at the pharmacy counter.

We're already seeing the dynamic when leadership discouraged COVID vaccination in pregnancy outside the ACIP process: pregnant people report being turned away at pharmacies. If ACIP now formally narrows or withdraws recommendations, then we can expect more denials or out-of-pocket charges. These products are not cheap—on the order of $140 per dose.

Professional societies will issue guidance, but they can't fix the statutory links that tie coverage to ACIP's votes.

Vaccines and autism: Kennedy's "big lie"

BM: Given their track record, the antivaccine movement and distortion of scientific data, do you expect an effort to revive claims linking vaccines to autism? And could they succeed in mainstreaming that?

DR: That's a real concern. One effect of this ACIP meeting—and of the broader shift under Kennedy—is to hand false anti-vaccine claims a much bigger microphone. Even parents who sense something is off may still think, *"If officials are saying this, maybe there's something there—should I risk it?"* Fear like that can push families away from protecting their children.

To be specific, there's no autism item on this specific meeting's agenda, but ACIP plans to discuss the hepatitis B birth dose and MMRV (measles, mumps, rubella, varicella). I worry they'll narrow or remove recommendations, making access harder.

I also expect misuse of VAERS. VAERS accepts unverified reports from anyone; it cannot establish causation for an injury or death. Saying "a death was reported to VAERS after a vaccine" is *not* evidence the vaccine caused it. Using VAERS as causal proof misleads parents and drives a dangerous wedge between public health and the population: skipping vaccination is the real danger, because of anecdote-driven fear based on falsified and erroneous evidence. So yes, I expect attempts to re-legitimize autism myths indirectly, by casting doubt on safety, using bad readings of data and platforming fringe analyses.

BM: Anti-vaccine figures are notorious for misrepresenting VAERS data for their agenda. The Geiers are a prime example of it, and now David Geier is advising Kennedy on autism. And with unlimited access to CDC databases that they can cherry-pick to their hearts' content, the complete falsification of the science behind vaccines is assured, yes?

DR: Exactly. And you're referring to Mark and David Geier. Mark, David's father, died in March, which is why we're now focused on David. In the early 2000s they published a string of thimerosal–autism papers which have been repudiated by experts. They later lost federal data access after trying to get around privacy protections in restricted datasets. They also pushed a dangerous "Lupron protocol," a powerful drug used to treat prostate cancer and precocious puberty, as treatment for autistic children, built on a contrived, debunked idea that "mercury" in the vaccines interacted and elevated testosterone levels. That was baseless and unethical.

Clearly, David Geier at HHS with access to the Vaccine Safety Datalink is disturbing. Now, the VSD is de-identified, and access is limited—no one gets a free run of full medical records. But the problem isn't just privacy; it's what gets *said* about the numbers. David Geier has a long history of misrepresenting data, slicing and re-slicing it to make it say what it doesn't and then presenting that as fact. He's been doing that for decades. It's really concerning to see someone like that in HHS right now.

BM: Given everything happening inside the United States—leadership changes at HHS/CDC/ACIP, politicized guidance, and widening skepticism—what are the international consequences? I'm thinking specifically about the World Health Organization and global emergency readiness.

DR: CDC has been a leader in global pandemic response and front-line technical partner for global health—training field epidemiologists, standing up labs, running surveillance, and deploying teams during crises. When the U.S. steps back from these global responsibilities, two things happen: there's less money and less expertise available to respond to emerging threats. We saw the value of that capability during West Africa's Ebola outbreak and many smaller responses people never hear about. Pulling out of the WHO will have serious consequences.

Trust has already taken a hit internationally. Information-sharing slows, joint studies stall, and genomic surveillance falls behind. Outbreak response becomes underfunded. Meanwhile, anti-vaccine messages from U.S. officials travel fast. They undercut measles and polio campaigns abroad and complicate vaccine procurement, because many countries take their cues from the U.S.

Practically, expect fewer catch-up campaigns, thinner stockpiles (syringes, PPE, and specialized vaccines), and stalled tech transfer—including momentum behind mRNA platform hubs. The International Health Regulations still bind the U.S. (early notification, cooperation, proportionate measures), but they only work with domestic follow-through. If our coverage drops and outbreaks spread outward, other countries may impose entry requirements or travel advisories that affect trade and movement.

Pathogens ignore borders. Politics doesn't change that. The short-term politics of "going it alone" turns into long-term risk and isolation for the U.S. and everyone else.

BM: Who are the key organizations and networks working to roll back vaccine rules? How have they embedded themselves in today's political structures and social media?

DR: The group of activists is small but has a significant impact relative to its size. In the U.S., many anti-vaccination organizers have more resources and social capital—well-educated, media-savvy, and connected to donors, lawyers, and political networks—so they can shape narratives, file lawsuits, and lobby effectively despite their numbers.

In the late 1990s and early 2000s, some held seats on federal advisory committees, and the press routinely booked them. They sounded polished—some had PR backgrounds—and figures like Andrew Wakefield could seem persuasive on camera even while pushing false claims about MMR and autism. As evidence accumulated against those claims, mainstream outlets pulled back, though local media and talk formats kept a door open.

In recent years they've rebranded. Instead of leading with "vaccines are dangerous," they front-load "medical freedom," constitutional language, and parental rights—while still working to reduce vaccination in practice. If it were truly about freedom, they wouldn't try to remove other people's access to vaccines.

They also aligned with right-wing media and political networks, which vastly expanded their reach. You see regular platforms for attorney Aaron Siri (who represents anti-vaccine groups) and physicians like Peter McCullough, alongside a constellation of influencers repeating the talking points. When a trusted outlet amplifies a message, audiences absorb these

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stories.

And these don't respect borders either. Internationally, these networks are well connected. U.S. narratives show up in the U.K., Germany, and France; Australian or European claims flow back here. They share tactics, legal briefs, funding leads, and media assets, building an international community.

Conclusion: The cost of anti-vaccine actions

BM: I'd like to conclude by asking if you have any final thoughts you'd like to share. Also, maybe consider commenting on two papers you wrote in 2014: "Funding the cost of disease outbreak caused by non-vaccination" and "Compensating the victims of failures of vaccinated." I thought they were very interesting.

DR: I always start from the basic premise that no one deserves to be hurt or killed by a preventable disease. I also think many people who are anti-vaccine are sincere, but they are working off disinformation and a completely different reality. But sincerity doesn't undo the harm to others. And I do think some movement leaders are willing to bend or ignore facts to push their cause.

Anti-vaccine actions impose real costs—lives, long-term health, money—on everyone else. It's a good idea to limit their ability to do that. Yet, we're seeing government choices that chip away at vaccination, which predictably raises non-vaccination and brings disease back. That's bad for all of us.

On the two 2014 articles you mentioned, the idea is straightforward: outbreaks are expensive. Even small measles outbreaks run into millions just for the public-health response, even before you count hospitalizations or long-term consequences. It's reasonable to bring some of those costs back to those who created the risk, ideally the leaders driving the disinformation, rather than leaving everyone else to pay. The goal isn't punishment; it's fairness and deterrence, so fewer families ever have to face these diseases.

BM: One last point: vaccination coverage among two-year-olds in Florida is down to about 75 percent.

DR: That's far too low. Florida's leaders are essentially running a natural experiment on what will happen if we let measles, Hib, and polio come back in children. The people making these decisions won't pay the price—children and their families will.

BM: And Florida Surgeon General Joseph Ladapo has said he didn't need to do an analysis because this is "purely a moral question."

DR: It is a dangerous stance, but I'm almost glad he said it plainly. He admits he didn't check whether these policies will bring back disease. He's saying it's more important, morally, in his view, to let parents send children to school unprotected than to determine whether he's protecting children. Elevating an abstract principle over kids' safety isn't acceptable.

BM: I'd call Ladapo's comments hubris.

DR: Yes.

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Major legal cases and rulings in the United States on public health and vaccinations:

· *Jacobson v. Massachusetts* [U.S. Supreme Court, 1905. Upheld a local smallpox vaccination requirement as a valid use of state police power, emphasizing that liberty isn't absolute during epidemics. The Court allowed a modest fine for refusal rather than forced inoculation. This case is the backbone for modern vaccination and exclusion rules.]

· *Zucht v. King* [U.S. Supreme Court, 1922. Affirmed that cities can require vaccination for public and private school attendance, and that health authorities may exercise broad—but not arbitrary—discretion. This solidified school-entry vaccination as a lawful tool.]

· *Prince v. Massachusetts* [U.S. Supreme Court, 1944. In a child-labor/First Amendment case, the Court stated that religious liberty does not include the right to expose the community or a child to communicable disease. Frequently cited to support outbreak exclusion and limits on exemptions.]

· *Gottsdanker v. Cutter Laboratories* [Cal. Ct. App., 1960. After the 1955 "Cutter Incident," a jury found no negligence but imposed liability on implied-warranty grounds for live poliovirus in Salk vaccine lots. It signaled that manufacturers could face liability even when meeting then-current standards, shaping later vaccine-liability debates.]

· *Toner v. Lederle Laboratories* [9th Cir., 1987. Upheld a negligence verdict alleging the DTP manufacturer failed to adopt a safer feasible design, even as strict-liability claims failed. Often cited to illustrate the pre-VICP tort climate that pushed manufacturers to the brink.]

· *Davis v. Wyeth Laboratories* [9th Cir., 1968. Recognized a duty to warn consumers directly in mass-immunization settings where no individualized physician advice occurs. Narrowed the learned-intermediary shield during public campaigns.]

· *Reyes v. Wyeth Laboratories* [5th Cir., 1974. Reinforced Davis: failure to provide adequate warnings in mass clinics could render the product unreasonably dangerous. Key backdrop to warning-duty law during immunization drives.]

· *Whitecotton v. Shalala* [U.S. Supreme Court, 1995. Clarified that to use the Vaccine Injury Table's presumption in VICP, onset must be after vaccination; pre-vaccination manifestations defeat the presumption. A cornerstone timing rule inside VICP.]

· *Althen v. HHS* [Fed. Cir., 2005. Set the three-prong VICP causation test: reliable medical theory, logical sequence, and appropriate timing, proven by preponderance. Establishes the program's claimant-friendly but evidence-based standard.]

· *Bruesewitz v. Wyeth* [U.S. Supreme Court, 2011. Held that the 1986 Vaccine Act preempts design-defect suits for covered vaccines; claims must go through VICP. This locked in the legal channel that stabilizes supply.]

· *NFIB v. OSHA* [U.S. Supreme Court, 2022. Stayed OSHA's large-employer vaccine-or-test rule under the "major questions" doctrine, signaling limits on broad federal mandates. Contrasts with the health-care–specific ruling below.]

· *Biden v. Missouri* [U.S. Supreme Court, 2022. Upheld CMS's vaccination requirement for Medicare/Medicaid-participating facilities based on patient-safety statutes. Shows sector-specific mandates fare better than economy-wide ones.]

· *Autism Omnibus Proceeding* [U.S. Court of Federal Claims, 2009–2010. Consolidated test cases alleging vaccines cause autism and rejected those theories after extensive expert evidence; appellate courts affirmed. This remains the definitive legal record on the claim.]

· *Hannah Poling* (VICP concession) [2008. Government conceded compensation where routine vaccines aggravated a rare mitochondrial disorder, producing encephalopathy with autism-like features. A narrow, case-specific outcome often misrepresented as a general autism finding.]

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