No. 23-996

In The
Supreme Court of the United States

JEANNA NORRIS, et al.,

Petitioners,

v.

SAMUEL L. STANLEY, JR., et al.,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

AMICUS CURIAE BRIEF OF DR. JAY BHATTACHARYA AND DR. MARTIN KULLDORFF IN SUPPORT OF PETITIONERS

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INTERESTS OF AMICUS AND RULE 37.6 DISCLOSURE[1]

Dr. Jay Bhattacharya is a former Professor of Medicine (20+ years), current Professor of Health Policy at Stanford University School of Medicine, and a research associate at the National Bureau of Economic Research. He is also Director of Stanford's Center for Demography and Economics of Health and Aging. He holds an M.D. and Ph.D. from Stanford University. He has published 154 scholarly articles in peer-reviewed journals about medicine, economics, health policy, epidemiology, statistics, law, and public health, among others. His research has been cited in the peer-reviewed scientific literature more than 11,600 times. He has dedicated his professional career to analyzing health policy, including infectious disease epidemiology and policy, and the safety and efficacy of medical interventions. He has studied extensively and commented publicly on the necessity and safety of vaccine requirements for those who have contracted and recovered from COVID-19 (individuals with "natural immunity"). He is intimately familiar with the emergent scientific and medical literature on this topic and pertinent government policy responses to the issue both in the United States and abroad.

Dr. Martin Kulldorff, Ph.D., Dr.h.c., is an epidemiologist and biostatistician. He was most recently on the

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[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than amicus or its counsel made a monetary contribution to fund the preparation or submission of the brief. Counsel for the parties were given notice of the intention to file this brief and consented to its filing.

Harvard University Medical School faculty for twenty years, including eleven years as Professor of Medicine. Dr. Kulldorff's research centers on developing and applying new disease surveillance methods for post-market drug and vaccine safety surveillance and early detection and monitoring of infectious disease outbreaks. Dr. Kulldorff has developed new sequential statistical methods for near real-time post-market drug and vaccine safety surveillance, where the purpose is to use weekly or other frequent data feeds to find potential safety problems as soon as possible. He has also developed tree-based scan statistic data mining methods for post-market drug and vaccine safety surveillance. These methods are used by the FDA and Centers for Disease Control and Prevention (CDC) to monitor drug and vaccine safety. Dr. Kulldorff received his bachelor's degree in mathematical statistics from Umeå University in Sweden and his doctorate in operations research from Cornell University. Before Harvard, he worked at Uppsala University in Sweden, the National Institutes for Health, and the University of Connecticut. He has written over 200 peer-reviewed publications, and he has given numerous scientific seminars and workshops on vaccine safety and disease outbreaks, including, for example, a 2011 workshop on "A Space-Time Permutation Scan Statistics for the Early Detection of Disease Outbreaks" at the Food Safety Biosurveillance Workshop at Michigan State University.

In October 2020, Drs. Bhattacharya and Kulldorff co-authored the Great Barrington Declaration,

advocating for a pandemic strategy of focused protection instead of school closures and population-wide lockdowns. Great Barrington Declaration and Petition, *Great Barrington Declaration* (2023), https://gbdeclaration.org/; *see also* Peter Robinson & Dr. Jay Bhattacharya, *The Man Who Talked Back: Jay Bhattacharya on the Fight against COVID Lockdowns*, HOOVER INSTITUTION (May 18, 2023), https://tinyurl.com/38mh5njt. Yet their views, reflecting basic principles of public health thinking, resulted in bitter personal and professional attacks against them, some initiated by high-ranking members of the federal government. At the behest of the federal government, Dr. Kulldorff was censored on social media for stating that people with infection-acquired immunity do not need the COVID-19 vaccine, even though infection-acquired immunity is superior to vaccine-induced immunity for COVID-19. And ironically, he was removed from the CDC's COVID-19 Vaccines Safety Technical Work Group (VaST) in retaliation for arguing against the "pause" in the Johnson and Johnson vaccine distribution as likely costing lives—a policy position the CDC eventually adopted. Joy Pullmann, *Colleagues Silent on CDC Retaliation against "Superstar" Scientist*, THE FEDERALIST (May 7, 2021), https://tinyurl.com/ysw4736s. As such, he may be the only person fired by the CDC for holding a position that was too pro-vaccine.

The epidemiological evidence, however, grows stronger every day, confirming conventional medical thinking and showing that the Great Barrington Declaration got things right. Lockdowns did little to stop

the virus and imposed incalculable public health damage upon the nation in terms of cancer care and survival, cardiovascular disease mortality, plummeting childhood vaccination rates, worsening mental health, and falling educational test scores, to name a few.

Rather, as the Great Barrington Declaration argued, targeted vaccinations to protect those at risk, rather than universal mandates for all healthy individuals of whatever age as Michigan State University imposed, has proven to be the best approach.

SUMMARY OF ARGUMENT

Michigan State University (MSU) mandated that students, faculty, and staff with infection-acquired immunity (natural immunity) receive COVID-19 vaccinations. Its mandate lacks any rational scientific basis. As has been known since ancient Greece and as modern-day physicians universally accept, individuals who recover from an infectious disease have infection-acquired immunity to that disease, which is superior to vaccine-induced immunity, as appears to be the case with COVID-19. For MSU to question infection-acquired immunity is as indifferent to scientific reason as if it had claimed the world is flat.

We are scientists and, on the one hand, understand the phrase "rational basis" to mean firmly grounded in empirical evidence. We understand, on the other hand, that the phrase has a different meaning in constitutional law. This Court has explained that the

term includes "rational speculation unsupported by evidence or empirical data." *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 307 (1993).

But the Sixth Circuit's opinion departs from the Court's understanding of rational basis in the substantive due process context—as well as any scientists'—by failing to realize that while evidence need not directly support all "rational speculation," MSU had no "rational basis" to ignore scientific facts.

Under the rational basis test, the Sixth Circuit had a duty to determine whether a "state of facts reasonably can be conceived," *Allied Stores of Ohio v. Bowers*, 358 U.S. 522, 528 (1959); *New York Rapid Transit Corp. v. City of New York*, 303 U.S. 573, 578 (1938), in which infection-acquired immunity does not exist or need not be considered when issuing vaccine mandates. It is the scientific consensus that no such state of facts exists.

In *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), this Court accepted as rational and legitimate the governmental goal of reducing smallpox. It rejected the plaintiff's claim that vaccines were inherently dangerous as a general matter and therefore found vaccine mandates a rational means to achieve that goal. This Court, after an exhaustive examination of the then-century-long history of smallpox vaccinations, recognized that to "[t]he matured opinions of medical men everywhere, and the experience of mankind," *id.* at 37, smallpox vaccinations are safe. It upheld Massachusetts's vaccine mandate.

Contradicting *Jacobson* and this Court's due process precedent, the Sixth Circuit failed to examine whether MSU's mandate had a rational basis even though MSU did not consider mainstream medical views on infection-acquired immunity. Rather, in a bit of legal legerdemain, the Sixth Circuit said that because *Jacobson* rejected substantive due process challenges to vaccine effectiveness in general, all such challenges are barred. *See Norris v. Stanley*, 73 F.4th 431, 435–37 (6th Cir. 2023). But here, the plaintiffs have different claims about vaccine mandates than in *Jacobson*, and *Jacobson* requires an examination of this case's plaintiffs' claim: whether the fact of infection-acquired immunity eliminates any rational basis for MSU's vaccine mandate.

MSU might argue that it followed prevailing wisdom among certain institutions as leading government agencies such as the CDC advocated vaccinating those with infection-acquired immunity. *See* Stanley Resp. Br., 2022 WL 3227804, at *9, (Aug. 3, 2022). But the prevailing wisdom among certain institutions is not the same as a rational basis. Another case before this Court this term, *Murthy v. Missouri*, No. 23A243, demonstrates how the government manipulated and controlled public discussion about COVID-19. Indeed, NIH Director Dr. Francis Collins called for a "swift and devastating takedown" of Drs. Bhattacharya and Kulldorff and their co-authors of the Great Barrington Declaration in an email to Dr. Anthony Fauci. *Missouri v. Biden*, No. 3:22-CV-01213, 2023 WL 4335270, at *25 (W.D. La. July 4, 2023)), *aff'd in part, rev'd in part*, 80

F.4th 641 (5th Cir. 2023), *opinion withdrawn and superseded on reh'g*, 83 F.4th 350 (5th Cir. 2023). Given that the Great Barrington Declaration proved correct, deference to such prevailing "wisdom" does not merely lack rational basis; it is perverse.

Historians will no doubt judge our government's COVID-19 response as a series of grievous institutional failings caused by incompetence, bureaucratic power-grabbing, corporate self-interest, and, above all, fear. This case asks whether substantive due process protects individuals against intrusions on bodily autonomy when government judgment goes awry. And that certainly happened with our government's COVID-19 response, as eminent epidemiologist Mark Woolhouse describes in his book, *The Year the World Went Mad: A Scientific Memoir* (Sandstone Press, 2022).

Justice Brewer famously wrote, "Constitutions . . . are rules prescribed by Philip sober to control Philip drunk." David J. Brewer, *Proc. of the New York State Bar Ass'n, Sixteenth Ann. Meeting: The Nation's Safeguard* 45 (N.Y. State Bar Ass'n, 1893). Certainly, understanding rational basis review as requiring that the government open its eyes to obvious scientific facts, like infection-acquired immunity, is such a rule.

Finally, although the Sixth Circuit applied rational basis scrutiny, *Jacobson*, in fact, requires heightened scrutiny. And, under any heightened scrutiny, the MSU policy makes no sense because it ignores infection-acquired immunity. Mandating the vaccine

for those who did not need it reduced the supply of vaccines for those who did need it, both in America and around the world, leading to more COVID-19 deaths than necessary. The MSU vaccine mandates were thus not only unscientific but also unethical, and those who refused vaccination took a brave, scientific, and ethical stand. Moreover, with the well-established evidence about myocarditis and other side effects, particularly for young men, together with the minuscule COVID-19 mortality risk for young adults, it is unclear whether the benefit-risk ratio is positive for university students.

ARGUMENT

The Sixth Circuit ignored this Court's rational basis precedent by ruling that substantive due process allows MSU to ignore established scientific understanding and conventional wisdom. Given the undisputed existence of infection-acquired immunity to COVID-19, which evidence reveals was stronger than vaccine-induced immunity, the MSU vaccine mandate lacks a rational basis. Further, COVID-19 vaccines do, in fact, pose medical risks, especially to young people, and COVID-19 only spreads, except in the rarest circumstances, through symptomatic individuals. A rational response, particularly under the heightened standard of *Washington v. Glucksberg*, 521 U.S. 702 (1997) and *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990), would allow symptomatic

individuals to take sick days and only return to work after testing negative for active infection.

I. The Sixth Circuit ignored this Court's precedent in ruling that rational basis review demands blindness to scientific fact.

The Sixth Circuit "base[d its] . . . standard of review on *Jacobson v. Massachusetts*, 197 U.S. 11 (1905)," explaining that it will uphold government distinctions "if any state of facts reasonably can be conceived that would sustain it." *Norris v. Stanley*, 73 F.4th 431, 435–36 (6th Cir. 2023) (quotations omitted). In applying the first step of rational basis review, the Sixth Circuit correctly states that it should "apply a strong presumption of validity . . . if the state's action furthers a legitimate state interest." *Id.* at 436.

In the next step of rational basis review, examining whether MSU's chosen means to further its governmental interest—mandatory vaccination of those with infection-acquired immunity—furthers this legitimate state interest, the Sixth Circuit failed to follow this Court's precedent. The Sixth Circuit states that "while plaintiffs argue that the research they cite shows that vaccinating naturally immune individuals carries little to no benefit, that argument is not enough to strike down the vaccine requirement under rational basis review in the face of a rational basis for MSU's policy." *Id.*

But the question is not simply whether there is a basis for MSU's governmental interest. Instead, a

reviewing court must also determine "if any state of facts reasonably can be conceived that would sustain" the *means* the government has chosen to further that interest. *New York Rapid Transit Corp. v. City of New York*, 303 U.S. 573, 578 (1938). Here, the Sixth Circuit failed to conduct a rational basis review of the means—it never asked whether the "state of facts" could sustain MSU's decision to mandate vaccines for those with infection-acquired immunity. And no state of facts would sustain MSU's policy because natural immunity is a universally accepted medical fact.

On that score, rather than follow this Court's precedent, the Sixth Circuit engages in legerdemain—conflating its determination that vaccines further a rational and legitimate governmental interest with whether there is a rational basis in the "state of facts" for mandating vaccines for those with infection-acquired immunity. The Sixth Circuit states:

> The scientific consensus around the smallpox vaccine was contested in [*Jacobson*] just as plaintiffs challenge the science underlying natural immunity compared with vaccine immunity here. The Supreme Court was not convinced by these arguments in 1905 [in *Jacobson*] . . . we are bound to apply that decision to reject plaintiffs' arguments here.

Norris, 73 F.4th at 436.

But *Jacobson* "bound" the Sixth Circuit to answer the question of whether a "state of facts" exists that can form a "rational basis" for a vaccine mandate that ignores infection-acquired immunity. *Jacobson* only

stands for the proposition that, in 1904, the medical consensus was that vaccines are, in general, a safe means to further the legitimate government interest in preventing disease—the question Jacobson appealed.

Ignoring *Jacobson*, the Sixth Circuit absolves a reviewing court from examining whether the "state of facts" provides a "rational basis" for the means the government chooses to further disease prevention. Following the Sixth Circuit's logic, MSU could mandate its employees and students undergo any controversial medical procedure, from male circumcision to preventative mastectomies for women with predictive genetic markers. In each, there would be a legitimate government goal, decreased disease prevalence, and questions about the scientific consensus.

The Sixth Circuit dismisses the scientific consensus concerning infection-acquired immunity (natural immunity) with one sentence: "The scientific consensus around the smallpox vaccine was contested in [*Jacobson*] just as plaintiffs challenge the science underlying natural immunity compared with vaccine immunity here." *Id.* (citing *Jacobson*, 197 U.S. at 30). But, unlike the Sixth Circuit, this Court in *Jacobson*, in fact, looked to the evidence from the then-100-year history of smallpox inoculations and concluded that "[t]he matured opinions of medical men everywhere, and the experience of mankind, as all must know, negative the suggestion that it is not possible in any case to determine whether vaccination is safe." *Jacobson*, 197 U.S. at 37.

The Sixth Circuit, contradicting *Jacobson*, did not look at the "matured opinions of medical men," which unequivocally show that there is no rational basis for mandating vaccines for those with infection-acquired immunity. The Sixth Circuit embraces a false logic that whenever there is an alleged dispute in the wisdom of a vaccine mandate, the government can use medical consensus to justify its mandates—but plaintiffs can never look to medical consensus to challenge the mandate. Rational basis review may be a deferential standard, but it cannot mean that "heads government wins, tails plaintiffs lose."

II. The medical consensus holds that natural immunity exists, and it is a relevant factor in vaccination decisions.

It is basic immunology that those who survive a disease usually have infection-acquired immunity to it. Thucydides observed this phenomenon during the famous plague that struck the city of Athens in 430 B.C. during the Spartan siege in the Peloponnesian War. *See* Thucydides, *History of the Peloponnesian War*, V.II, 3–54 (P.J. Rhodes Trans., Bloomberg Publ'g 2015) ("[T]he disease did not attack the same person a second time, or at any rate not fatally.") And the principle is part of basic medical healthcare advice that even the CDC accepts. For instance, it does not advise those who

have contracted chickenpox to receive the chickenpox vaccination.[2]

Rather, when MSU issued its mandate in July 2021, it was unclear in the scientific literature how long-lasting vaccine-induced immunity would be. On the other hand, the medical community widely accepted infection-acquired immunity for COVID-19. That the scientific community believed in the existence of COVID-19's infection-acquired immunity can be shown by the research conducted at the time. For instance, in one prominent study, the researchers argue that they can best surmise the predicted durability of vaccine immunity by looking at the expected durability of infection-acquired immunity.[3] As another example, for the randomized clinical trial of their COVID-19 vaccine, Pfizer excluded people with infection-acquired immunity in their first primary endpoint analysis.[4]

Thus, even at the beginning of the epidemic, MSU acted without a rational basis when it refused to consider infection-acquired immunity in its mandate.

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[2] Centers for Disease Control and Prevention, *Chickenpox Vaccination: What Everyone Should Know* (2021), https://tinyurl.com/CDCchipox.

[3] Heidi Ledford, *Six Months of COVID Vaccines: What 1.7 billion Doses Have Taught Scientists*, 594 NATURE 164, 164–167 (2021). (noting that "[s]ix months is not much time to collect data on how durable vaccine responses will be. . . . In the meantime some researchers are looking to natural immunity as a guide.").

[4] Pfizer-BioNTech, *Pfizer-Biontech COVID-19 Vaccine (BNT162, PF-07302048) Vaccines and Related Biological Products Advisory Committee Briefing Document: 10 December 2020 Meeting* (Nov. 30, 2020), https://tinyurl.com/PfizerBrief.

But, as expected, the overwhelming evidence developed since confirms the conventional wisdom that individuals who previously contracted COVID-19 have infection-acquired immunity. An Israeli study found that the vaccinated have a 27 times higher risk of symptomatic infection than the COVID-19 recovered.[5]

At the same time, the COVID-19 vaccines provide limited protection against infection over time, and vaccinated individuals may shed the virus as much as unvaccinated individuals. A recent study, which tracked 927,321 individuals for six months after vaccination, concluded that the Pfizer vaccine's "induced protection against infection appears to wane rapidly after its peak right after the second dose. . . ."[6]

That study is not an outlier. A large study in California tracked the infection rates for nearly five million patients vaccinated with two doses of the Pfizer mRNA vaccine and showed similar results.[7] Another recent study tracked 620,000 vaccinated U.S. veterans to measure breakthrough infections for the three types of

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[5] Sivan Gazit, et al., *Comparing SARS-CoV-2 Natural Immunity to Vaccine-Induced Immunity: Reinfections Versus Breakthrough Infection*, MEDRXIV. (2021), https://doi.org/10.1101/2021.08.24.21262415.

[6] Hiam Chemaitelly, et al., *Waning of BNT162b2 Vaccine Protection against SARS-CoV-2 Infection in Qatar*, 385(24) N. ENGL. J. MED. e83(1) (2021).

[7] Sara Tartof, et al., *Effectiveness of mRNA BNT162b2 COVID-19 Vaccine up to 6 Months in A Large Integrated Health System in the USA: A Retrospective Cohort Study*, 398 LANCET 1407 (2021).

COVID-19 vaccines in common use in the U.S.[8] This study corroborates yet another study that documented declining vaccine efficacy in the first three months after vaccination against disease transmission in the era of the Delta variant.[9] And yet another study, a Wisconsin study, confirmed that vaccinated individuals can shed infectious SARS-CoV-2 viral particles.[10] The authors analyzed nasopharyngeal samples to check whether patients showed evidence of infectious viral particles. They found that vaccinated individuals were at least as likely as unvaccinated individuals to be shedding live virus. They concluded:

> Combined with other studies these data indicate that vaccinated and unvaccinated individuals infected with the Delta variant might transmit infection. Importantly, we show that infectious SARS-CoV-2 is frequently found even in vaccinated persons.[11]

In sum, the evidence to date strongly confirms the medical conventional wisdom: that while vaccines—like infection-acquired immunity—protect against severe disease, they, unlike infection-acquired immunity,

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[8] Barbara A. Cohn, et al., *Breakthrough SARS-CoV-2 Infections in 620,000 U.S. Veterans, February 1, 2021 to August 13, 2021*, MEDRXIV. (2021), https://doi.org/10.1101/2021.10.13.21264966.

[9] David W. Eyre, et al., *The Impact of SARS-CoV-2 Vaccination on Alpha & Delta Variant Transmission*, MEDRXIV. (2021), https://doi.org/10.1101/2021.09.28.21264260.

[10] Kasen K. Riemersma, et al., *Shedding of Infectious SARS-CoV-2 Despite Vaccination*, PLOS PATHOG 18(9): e1010876 (2022), https://tinyurl.com/338e5tc3.

[11] *Id.*

provide only short-lasting protection against subsequent infection and disease spread. Put simply, there is no medical or scientific reason to believe that vaccine immunity will prove longer lasting than infection-acquired immunity, much less that all currently approved vaccines will be expected to prove more durable than infection-acquired immunity despite their different technological foundations and dosing protocols.

III. Under the correct standard of review, MSU's vaccine policy was unjustified.

Courts must review government mandates that invade bodily autonomy with scrutiny greater than rational basis review. In *Jacobson*, a decision pre-dating the emergence of modern levels of scrutiny, the Court applied what can only be termed intermediate scrutiny. There, the Court pointed out that society faces "great dangers" from infectious disease, 197 U.S. at 29, and the smallpox vaccine mandate had a "substantial relation," *id.* at 31, to reducing these dangers. Further, in a long line of cases, the Court has recognized the centrality of bodily integrity, and the right to refuse medical treatment has been considered central to our notions of liberty that are "deeply rooted" in this Nation's history and traditions. *Rochin v. California*, 342 U.S. 165, 171 (1952).

Applying MSU's vaccine mandate makes no sense, particularly under these heightened standards. All pharmaceutical drugs and vaccines, including those for COVID-19, present some risk of injury. The common

side effects include pain and swelling at the vaccination site and fatigue, headache, muscle pain, fever, and nausea for a limited time after vaccination,[12] as well as less common but severe side effects such as allergic (anaphylactic) reactions.[13] Finally, the CDC's vaccine safety committee has identified rare but deadly side effects, including a heightened risk of clotting abnormalities[14] in young women after the Johnson & Johnson (J&J) vaccination, elevated risks of myocarditis and pericarditis[15] in young people—but especially young men—after mRNA vaccination, and higher risk of Guillane-Barre Syndrome[16] after the J&J vaccine. A university, whose primary mission is, after all, to educate young people, must consider the heightened risks to young people when mandating vaccines.

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[12] Centers for Disease Control and Prevention, *Possible Side Effects after Getting a COVID-19 Vaccine* (2021), https://tinyurl.com/3rjc3f7z.

[13] Centers for Disease Control and Prevention, *What to Do If You Have an Allergic Reaction after Getting a COVID-19 Vaccine* (2021), https://tinyurl.com/COVIDallergicreaction.

[14] Martin Kulldorff, *The Dangers of Pausing the J&J Vaccine*, THE HILL (Apr. 17, 2021), https://tinyurl.com/48ju2um3.

[15] Centers for Disease Control and Prevention, *Clinical Considerations: Myocarditis and Pericarditis after Receipt of mRNA COVID-19 Vaccines among Adolescents and Young Adults* (2021), https://tinyurl.com/4jwbrdx4.

[16] Sharon LaFraniere & Noah Weiland, *FDA Attaches Warning of Rare Nerve Syndrome to Johnson & Johnson Vaccine*, THE NEW YORK TIMES, (July 12, 2021), https://tinyurl.com/3n5tyerj.

Considering these undisputed risks, it would be rational to protect against the spread of the disease without imposing such risks on people with superior infection-acquired immunity—and there is a way to do so for both vaccinated and unvaccinated staff and students. It turns on recognizing that people without COVID-19 symptoms rarely transmit the disease. The best evidence on how often asymptomatic disease spread occurs comes from a large meta-analysis of fifty-four studies worldwide on the within-household spread of the virus—that is, from an infected person to someone else living in the same home.[17] This study represents the most robust survey of the vast empirical literature on asymptomatic spread. The main result is that symptomatic patients spread the disease to household members in 18% of cases. By contrast, those infected but without symptoms (asymptomatic and pre-symptomatic) spread the infection to household members in only 0.7% of cases.[18]

MSU could have adopted a robust sick policy, requiring that both workers who have been and have not been vaccinated and who show symptoms consistent with COVID-19 infection stay at home from work, returning to work only once they have had a negative COVID-19 PCR or antigen test result. This could be implemented, for instance, by requiring workers to

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[17] Zachary Madewell, et al., *Household Transmission of SARS-CoV-2: A Systematic Review and Meta-analysis*, AMA NETW OPEN (2020), https://pubmed.ncbi.nlm.nih.gov/33315116/.

[18] *Id.*

complete a symptom self-check each day before coming to work.

Finally, it had become quickly understood that COVID-19 affects the elderly many orders of magnitude more than the young. When a vaccine can save lives, as the COVID-19 vaccine did for older people, and when there is a shortage of vaccines, it is highly unethical to mandate the vaccine to those who do not need it. Rather, the vaccines that MSU mandated for young people should have gone to the elderly both in this country and around the world.

CONCLUSION

For these reasons, the Court should grant the petition for certiorari.

Respectfully submitted,

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