

IN THE SUPREME COURT OF THE STATE OF OKLAHOMA

DR. VALERIE RITTER, *for herself as an individual and for and on behalf of her Minor Children RR and ER;*
KIMBERLY BUTLER, *for herself as an individual and for and on behalf of her Minor Child HB;*
MARY ANN MARTIN, *for herself as an individual and for and on behalf of her Minor Children KM, EM, and MM;*
DR. BRITNEY ELSE, *for herself as an individual and for and on behalf of her Minor Child BJ; and*
THE OKLAHOMA STATE MEDICAL ASSOCIATION, *an Oklahoma Not for Profit Corporation,*

Case No. 119,840

Plaintiffs/Appellees,

v.

THE STATE OF OKLAHOMA; and
THE HONORABLE KEVIN STITT, *in his official capacity as GOVERNOR OF THE STATE OF OKLAHOMA,*

Defendants/Appellants.

On Appeal from
District Court Case
No. CV-2021-1918

Judge: The Honorable Natalie Mai
Nature of Action: Injunction

BRIEF OF AMICUS CURIAE AMERICAN ACADEMY OF PEDIATRICS IN SUPPORT OF PLAINTIFFS/APPELLEES

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INTEREST OF *AMICUS CURIAE*¹

The American Academy of Pediatrics (“AAP”) was founded in 1930 and is a national, not-for-profit professional organization dedicated to furthering the interests of child and adolescent health. The AAP’s membership includes over 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. Over the past year-and-a-half, the AAP has devoted substantial resources to researching the scientific literature regarding how to treat COVID-19 and reduce its spread so that the AAP can provide up-to-date, evidence-based guidance for pediatricians and public health officials. This includes, among other things, interim guidance on the use of face masks as an infection control measure and on operating safe schools during the COVID-19 pandemic.²

¹ *Amicus* certifies that no party’s counsel authored this brief in whole or in part, no party or party’s counsel contributed money intended to fund this brief, and no person other than *Amicus*, their members, and their counsel contributed money intended to fund this brief.

² Pursuant to Oklahoma Supreme Court Rule 1.12(a), the undersigned counsel has obtained written consent from counsel for all parties to file this amicus brief.

INTRODUCTION

Over the past 20 months, *Amicus* has worked ceaselessly to evaluate the dangers of COVID-19 and potential public health measures for reducing its deadly spread. The AAP has conducted a comprehensive review of the medical literature to determine what public health measures can effectively reduce the risk that COVID-19 poses to America’s children. This comprehensive review and the experiences of the front-line pediatric practitioners who make up the AAP’s membership prove three relevant facts beyond any doubt: (i) COVID-19 poses grave risks to children, risks that escalated significantly with the rise of the Delta variant; (ii) universal mask policies in schools significantly reduce the spread of COVID-19 and protect all children; and (iii) masks do not harm children.

Despite these facts, on May 28, 2021, Governor Stitt signed into law Senate Bill No. 658 (“SB 658”), codified at Oklahoma Statute Title 70, Sections 1210.189-1210.191, which effectively prohibits a public school district from implementing a mask policy for students attending K-12 schools. The district court issued a temporary injunction preventing the law from taking effect. The State now asks this Court to vacate the district court’s injunction, arguing that SB 658 aims solely to “expand parent and student choice,” Appellant’s Br. at 1, and that the injunction Plaintiffs seek³ “would harm the parents and students who do not want masks forced upon students,” Appellant Br. at 14. To the extent that the State argues that requiring children to wear masks is harmful, this argument is demonstrably wrong. This brief provides an overview of the scientific literature rebutting this claim and explains why universal mask policies are so crucial in fighting COVID-19.

³ Plaintiffs ask this court to affirm the district court’s order enjoining the enforcement of SB 658 but to reverse the portion of the injunction that imports a parental opt-out requirement from mandatory vaccination statutes, Oklahoma Statute Title 70. §§ 1210.192-1210.193.

Matters involving a grant or denial of injunctive relief are of equitable concern, and the Court, therefore, considers all evidence on appeal. *Edwards v. Bd. of Cnty. Comm’rs of Canadian Cnty.*, 2015 OK 58, ¶ 11, 378 P.3d 54, 58. In doing so, the Court must consider whether “the injunction is in the public interest.” *Id.* at 59. As the Supreme Court of the United States has likewise explained, courts “should pay particular regard for the public consequences” when deciding whether to grant or deny injunctive relief. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008). Here, there is no question that the public interest points in favor of an injunction. Universal school mask policies substantially reduce the risk of death and serious illness among Oklahoma’s school-age population and their families, without any meaningful harm to mask-wearers. Schools that lack such policies experience significantly higher rates of COVID-19 transmission, and effectively deny a safe education to all children, but particularly the medically vulnerable. Accordingly, the Court should affirm the injunctive relief granted below, yet modify it to remove the parental opt-out provisions taken from the State’s vaccination statutes. Doing so will give school districts the ability to protect their students and communities through universal mask policies.

ARGUMENT

I. COVID-19 Is a Serious Childhood Illness

The State’s brief purports to balance “the liberty of parents and guardians to direct the upbringing and education of children” with the State’s need to regulate education in both public and private schools. Appellant’s Br. at 7 (citations omitted). The State’s brief, however, ignores the factual predicate upon which any regulation—here, any mask policy—would be imposed: the seriousness of pediatric COVID-19. The AAP and the Children’s Hospital Association have collaborated throughout the pandemic to collect and share all publicly

available data from states on COVID-19 cases among children.⁴ These data fully support a universal mask policy in Oklahoma's schools.

As of November 18, 2021, almost 6,900,000 total child COVID-19 cases have been reported in the United States, representing 17% of the total U.S. cases and 25.1% of reported weekly cases (despite children under the age of 18 making up 22.2% of the U.S. population).⁵ The prevalence of pediatric COVID-19 has skyrocketed since the school year began, with nearly a third of all child cases since the beginning of the pandemic 20 months ago diagnosed in the three and a half months between August 13 and November 25.⁶ This surge appears to be due to two principal factors: the resumption of in-person schooling (and particularly schooling in places without masks), and the emergence of the Delta variant, which is more than twice as contagious as previous variants.⁷

As the rate of COVID-19 has soared, so has the number of serious cases; just among the 24 states and one city that report child hospitalizations, nearly 8,400 children were hospitalized due to COVID-19 between August 13 and November 25, more than 30% of the total child hospitalizations to date.⁸ Before August 13, no more than 16 children had died from

⁴ See *Children and COVID-19: State-Level Data Report*, AAP, <https://bit.ly/31RMDLR> (data available as of Nov. 25, 2021).

⁵ *Id.*

⁶ *Children and COVID-19: State Data Report* at Appx. Tab. 2A, Children's Hosp. Ass'n & Am. Acad. of Pediatrics (Nov. 25, 2021), <https://downloads.aap.org/AAP/PDF/AAP%20and%20CHA%20-%20Children%20and%20COVID-19%20State%20Data%20Report%2011.25%20FINAL.pdf>

⁷ See *Delta Variant: What We Know About the Science*, CDC (Aug. 26, 2021), <https://bit.ly/3kDl7sc>.

⁸ See *Children and COVID-19: State Data Report*, *supra* n. 6, at Appx. Tab. 2B.

COVID-19 in any week of the pandemic; after August 13, that number was matched or eclipsed for 11 straight weeks.⁹

As the hospitalization rate reflects, COVID-19 can cause severe symptoms and potentially fatal outcomes, including in children. Among other things, COVID-19 infections can produce multisystem inflammatory syndrome in children (MIS-C).¹⁰ MIS-C involves clinically severe levels of fever, inflammation, and dysfunction or shock in multiple organ systems (including cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic, and/or neurological). Among other symptoms, it can cause coronary artery enlargement; aneurysm; meningitis; colitis; hepatitis; symptoms akin to toxic shock syndrome; thrombosis; acute kidney injury; stroke; encephalitis; congestive heart failure; and pulmonary embolism.

COVID-19 infections can also lead to many secondary conditions, ranging from subacute to severe. Several studies have shown that long-term symptoms can occur in children and adolescents.¹¹ Indeed, even cases with mild initial symptomatology can produce significant long-term effects. These include persistent respiratory symptoms ranging from chest pain, cough, and exercise-induced dyspnea to pulmonary emboli; myocarditis (i.e., inflammation of the heart muscle), shortness of breath, arrhythmia, and/or fatigue, potentially

⁹ *Id.* at Appx. Tab. 2C.

¹⁰ See *Multisystem Inflammatory Syndrome in Children (MIS-C) Associated with Coronavirus Disease 19 (COVID-19)*, CDC (May 14, 2020), <https://bit.ly/3niE5WG>; *Multisystem Inflammatory Syndrome in Children (MIS-C) Interim Guidance*, AAP (last updated Feb. 10, 2021), <https://bit.ly/3Cp8Nlu>.

¹¹ See, e.g., Danilo Buonsenso, et al., *Preliminary evidence on long COVID in children*, Acta Paediatrica (2021), <https://bit.ly/2YMGcsj> (studying 129 children in Italy and reporting that 42.6% experienced at least one symptom more than 60 days after infection); Helen Thomson, *Children with long covid*, 249 New Scientist 10 (2021), <https://bit.ly/3DquZgo> (U.K. Office of National Statistics estimate that 12.9% of children 2-11 years of age and 14.5% of children 12-16 years of age experienced symptoms 5 weeks after infection).

leading to heart failure, myocardial infarction, stroke, or sudden cardiac arrest; persistent loss of the sense of smell (anosmia) or taste (ageusia), which can affect the nutritional status and quality of life of children and adolescents and be particularly disruptive to the feeding behavior of very young children; neurodevelopmental sequelae, both including the consequences of significant acute injuries such as stroke or encephalitis and subtle but persistent sequelae in cognitive, language, academic, motor, mood, and behavioral domains; cognitive fogginess or fatigue; physical fatigue; and mental or behavioral health impacts such as stress and adjustment disorders.

II. Based on Extensive Research, the AAP Strongly Recommends that Schools Maintain Universal Mask Policies in Schools as an Infection-Control Measure.

A. Overview of AAP's Evidence-Based Guidance on School Safety During the Pandemic.

One of the AAP's chief functions is to provide evidence-based guidance to America's pediatric professionals and public health officials. To do so, the AAP issues Policy Statements that report the most up-to-date, evidence-based expert consensus on key issues of pediatric practice and public health. These Policy Statements are written by recognized pediatrician experts who undertake a comprehensive review of the medical literature and available data. They are then peer-reviewed by additional experts across the AAP and approved by the AAP's executive staff and board of directors.

Since the spring of 2020, the AAP's top focus has been supporting practicing pediatricians and public health policymakers in treating COVID-19 and reducing its spread, particularly among children. The AAP has issued Interim Guidance Statements on several topics related to COVID-19, including guidance on when and how pediatricians should test

patients for COVID-19;¹² on providing clinical care to patients with COVID-19;¹³ on treating post-COVID conditions;¹⁴ on how to safely provide routine medical care such as check-ups, screenings, laboratory exams, treatment, and immunizations during the COVID-19 pandemic;¹⁵ on caring for youth with special health needs during the COVID-19 pandemic;¹⁶ on supporting the emotional and behavioral health needs of children, adolescents, and families during the COVID-19 pandemic;¹⁷ and—most relevant to this case—on the use of face masks as an infection-control measure¹⁸ and on operating safe schools during the COVID-19 pandemic that foster the overall health of children, adolescents, educators, staff, and communities.¹⁹ These Interim Guidances were drafted and reviewed by numerous pediatricians with expertise in a wide variety of disciplines, and have been continually reviewed and updated since spring of 2020. By this point, the AAP's experts have reviewed

¹² *COVID-19 Testing Guidance*, AAP (last updated Nov. 17, 2021), <https://bit.ly/3cfroFQ>.

¹³ *COVID-19 Interim Guidance*, AAP (last updated Nov. 2, 2021), <https://bit.ly/3Djk1Jx>.

¹⁴ *Post-COVID-19 Conditions in Children and Adolescents*, AAP (last updated July 28, 2021), <https://bit.ly/3cuLhJj>.

¹⁵ *Guidance on Providing Pediatric Well-Care During COVID-19*, AAP (last updated Aug. 30, 2021), <https://bit.ly/3Dqxlf>.

¹⁶ *Caring for Children and Youth with Special Health Needs During the COVID-19 Pandemic*, AAP (last updated Sept. 20, 2021), <https://bit.ly/3DlqkvU>.

¹⁷ *Interim Guidance on Supporting the Emotional and Behavioral Health Needs of Children, Adolescents, and Families During the COVID-19 Pandemic*, AAP (last updated July 28, 2021), <https://bit.ly/3qGi5r2>.

¹⁸ *Face Masks*, AAP (last updated Nov. 15, 2021), <https://bit.ly/30p9qOD>.

¹⁹ *COVID-19 Guidance for Safe Schools*, AAP (last updated Nov. 2, 2021), <https://bit.ly/3DkCrcM>.

hundreds of articles related to the efficacy and safety of masks, as well as their effects (or lack thereof) on the cognitive, social, and psychological development of children.

As a pediatrician organization, the AAP recognizes that not being able to attend school in person can negatively affect children’s cognitive, educational, and social development, as well as children’s short- and long-term mood, behavior, and mental health. Based on the AAP’s expert review of the scientific literature and the guidance outlined by the World Health Organization, United Nations Children’s Fund, and Centers for Disease Control and Prevention (“CDC”), along with AAP’s members’ collective expertise as pediatricians and researchers, the AAP concluded that “all local, state, and federal policy considerations for school COVID-19 plans should start with a goal of keeping students safe, physically present, and emotionally supported in school.”²⁰ “At this point in the pandemic, given what we know now about low rates of in-school transmission *when proper prevention measures are used*, together with the availability of effective vaccines for those eligible, . . . the benefits of in-person school outweigh the risks in almost all circumstances.”²¹ Among the recommended prevention measures (such as immunization of all eligible individuals and adequate and timely COVID-19 testing), one of the most important is that “[a]ll students older than 2 years and all school staff should wear face masks at school (unless medical or developmental conditions prohibit use).”²²

This conclusion has been consistently reinforced by all relevant data and credible research, leading the Centers for Disease Control (“CDC”) to recommend “universal indoor

²⁰ *Id.*

²¹ *Id.* (emphasis added).

²² *Id.* (emphasis in original).

masking for all teachers, staff, students, and visitors to schools, regardless of vaccination status” on July 27, 2021.²³ Just last month, after reviewing all scientific evidence to date on the transmission and prevention of COVID-19 during the current school year, AAP reaffirmed its recommendation of universal masking.²⁴

B. Universal Masking Policies Are Highly Effective at Reducing Transmission of COVID.

While there are several reasons for the AAP’s (and the CDC’s) recommendation of universal masking in school,²⁵ the most important is that the research has confirmed that masks are both effective and safe. Masks “reduce the emission of virus-laden droplets . . . , which is especially relevant for asymptomatic or presymptomatic infected wearers who feel well and may be unaware of their infectiousness to others, and who are estimated to account for more than 50% of transmissions.”²⁶ Cloth masks “block most large droplets (i.e., 20-30 microns and larger)” and “also block the exhalation of fine droplets.”²⁷ “Multi-layer cloth masks can both block up to 50-70% of these fine droplets and particles,” with “[u]pwards of 80% blockage” recorded in some studies.²⁸ To a slightly lesser extent, masks also “help reduce inhalation of

²³ *Interim Public Health Recommendations for Fully Vaccinated People—Summary of Recent Changes*, CDC (Oct. 15, 2021), <https://bit.ly/3mmCmy6>.

²⁴ *COVID-19 Guidance for Safe Schools*, *supra* n. 19.

²⁵ *See id.* (identifying eight bases for AAP’s mask recommendation).

²⁶ *Science Brief: Community Use of Cloth Masks to Control the Spread of SARS-CoV-2*, CDC (May 7, 2021), <https://bit.ly/3utvxOA> (citations omitted).

²⁷ *Id.*

²⁸ *Id.*

these droplets by the wearer”; multi-layer cloth masks can filter out “nearly 50% of fine particles less than 1 micron.”²⁹

This difference between a mask’s ability to block *exhalation* and *inhalation* of viral particles explains why it is so important for mask policies to be universal. A mask’s primary benefit is as “source control,” preventing infected carriers from spreading viral particles widely. As the CDC has explained, “masks are not designed to reduce the particles that the wearer will inhale The purpose of wearing a mask is to help reduce the spread of COVID-19 by reducing the spread of the virus through respiratory droplets from asymptomatic individuals.”³⁰ Because wearing a mask provides only limited protection against contracting COVID-19 if the wearer is near one or more unmasked carriers, universal masking is needed as source control for COVID-19 carriers (who may be asymptomatic and not know they are shedding viral particles), thereby protecting vulnerable individuals.

Numerous studies have shown that increasing the rate of mask-wearing, including through universal mask policies in particular, significantly reduces the spread of COVID-19.³¹

²⁹ *Id.*

³⁰ *Respiratory Protection vs. Source Control—What’s the Difference?*, CDC (Sept. 8, 2020), <https://bit.ly/3pn0y6s>.

³¹ See, e.g., Jeremy Howard, et al., *An Evidence Review of Face Masks Against COVID-19*, 118 Proc. of the Nat’l Acad. of Servs. e2014564118 (2021), <https://bit.ly/3ndJVsl>; John T. Brooks & Jay C. Butler, *Effectiveness of Mask Wearing to Control Community Spread of SARS-CoV-2*, 325 J. of Am. Med. Ass’n 998 (2021), <https://bit.ly/3Fi8Hh7>; Heesoo Joo, et al., *Decline in COVID-19 Hospitalization Growth Rates Associated with Statewide Mask Mandates—10 States, March–October 2020*. 70 Morbidity & Mortality Weekly Rep. 212 (2021), <https://bit.ly/3cgPrEd>; Derek K. Chu, et al., *Physical Distancing, Face Masks, and Eye Protection to Prevent Person-to-Person Transmission of SARS-CoV-2 and COVID-19: A Systematic Review and Meta-Analysis*, 395 Lancet 1973 (2020), <https://bit.ly/3kEj1YU>; Christopher T. Leffler, et al., *Association of Country-wide Coronavirus Mortality with Demographics, Testing, Lockdowns, and Public Wearing of Masks*, 103 Am. J. Tropical Med. Hygiene 2400 (2020), <https://bit.ly/2YMIszO>; Miriam E. Van Dyke, et al., *Trends in County-Level COVID-19 Incidence in Counties With and Without a Mask Mandate—Kansas, June 1–*

In particular, studies have shown that masking and similar mitigation measures can limit transmission in schools.³² Most recently, the CDC released three studies conducted during this school year, all of which found that “school districts without a universal masking policy in place were more likely to have COVID-19 outbreaks.”³³ As the ABC Science Collaborative, a 13-state initiative coordinated by the Duke Clinical Research Institute at the Duke University School of Medicine, said: “[p]roper masking is the most effective mitigation strategy to prevent

August 23, 2020. 69 Morbidity & Mortality Weekly Rep. 1777 (2020), <https://bit.ly/31SbU8H>; Wei Lyu & George L. Wehby, *Community Use of Face Masks and COVID-19: Evidence from a Natural Experiment of State Mandates in the US*, 39 Health Aff. 1419 (2020), <https://bit.ly/3Ho9VJw>.

³² See, e.g., Patrick Dawson, et al., *Pilot Investigation of SARS-CoV-2 Secondary Transmission in Kindergarten Through Grade 12 Schools Implementing Mitigation Strategies—St. Louis County and City of Springfield, Missouri, December 2020*, 70 Morbidity & Mortality Weekly Rep. 449 (2021), <https://bit.ly/3HsAL3w>; Darria L. Gillespie, et al., *The Experience of 2 Independent Schools With In-Person Learning During the COVID-19 Pandemic*, 91 J. Sch. Health 347 (2021), <https://bit.ly/3kAEtxR>; Rebecca B. Hershaw, et al., *Low SARS-CoV-2 Transmission in Elementary Schools - Salt Lake County, Utah, December 3, 2020-January 31, 2021*, 70 Morbidity & Mortality Weekly Rep. 442 (2021), <https://bit.ly/3cb48ZE>; Amy Falk, et al., *COVID-19 Cases and Transmission in 17 K-12 Schools - Wood County, Wisconsin, August 31-November 29, 2020*, 70 Morbidity & Mortality Weekly Rep. 136 (2021), <https://bit.ly/3qFvxeD>; Fiona Russell et al., *COVID-19 in Victorian Schools: An Analysis of Child-Care and School Outbreak Data and Evidence-Based Recommendations for Opening Schools and Keeping Them Open*, Murdoch Children’s Rsch. Inst. & The Univ. of Melb. (2020), available at <https://bit.ly/31TpNU6>; see generally *Science Brief: Transmission of SARS-CoV-2 in K-12 Schools and Early Care and Education Programs—Updated*, CDC (Nov. 16, 2021), <https://bit.ly/2YRMJCe>.

³³ Press Release, *Studies Show More COVID-19 Cases in Areas Without School Masking Policies*, CDC (Sept. 24, 2021), <https://bit.ly/3kYtuyU>; see Megan Juhn, et al., *Association Between K–12 School Mask Policies and School-Associated COVID-19 Outbreaks—Maricopa and Pima Counties, Arizona, July–August 2021*, 70 Morbidity & Mortality Weekly Rep. 1372 (2021), <https://bit.ly/3uwVdKh>; Samantha E. Budzyn, et al., *Pediatric COVID-19 Cases in Counties With and Without School Mask Requirements—United States, July 1–September 4, 2021*, 70 Morbidity & Mortality Weekly Rep. 1377 (2021), <https://bit.ly/3uIQ8il>; Sharyn E. Parks, et al., *COVID-19–Related School Closures and Learning Modality Changes—United States, August 1–September 17, 2021*, 70 Morbidity & Mortality Weekly Rep. 1374 (2021), <https://bit.ly/3ipDVtD>.

COVID-19 transmission in schools when vaccination is unavailable or there are insufficient levels of vaccination among students and staff.”³⁴

To the extent there are questions about whether the need for a mask policy has been vitiated by the recent authorization of vaccines for five- to eleven-year-olds—which the State does not argue—the evidence is to the contrary. While pediatric vaccines are now *available* for children as young as five years old, few if any children between five and eleven have been fully vaccinated to date. Even children who got their first shot immediately after the CDC permitted vaccinating this age group on November 2, 2021 need to wait three weeks for their second shot,³⁵ and vaccine efficacy is not complete for seven to 14 days thereafter.³⁶ And it will take time for all or even a majority of children to receive the vaccine; even among 12- to 17-year-olds, who have been eligible for the vaccine for months, only 50% are fully vaccinated.³⁷

Vacating the injunction of SB 658 now would be especially dangerous because of the holiday season. Last year, Thanksgiving and Christmas ushered in the worst surge of the pandemic.³⁸ The weekly death rate reached a peak 50% higher than any point in the pandemic

³⁴ ABC Science Collaborative, *The ABCs of North Carolina’s Plan*, <https://bit.ly/3nhUYkr> (last visited Nov. 15, 2021); see also ABC Science Collaborative, *Final Report for NC School Districts and Charters in Plan A*, at 3 (June 30, 2021), available at <https://bit.ly/3cgHMWs>.

³⁵ See *COVID-19 Vaccines for Children and Teens*, CDC (Nov. 4, 2021), <https://bit.ly/3ouCoEY>.

³⁶ See *About the COVID-19 Vaccine: Frequently Asked Questions*, AAP (Nov. 12, 2021), <https://bit.ly/3ouUqHl>.

³⁷ See *Children and COVID-19 Vaccinations Trends*, AAP, at 3 (Nov. 17, 2021), <https://downloads.aap.org/AAP/PDF/Child%20Vaccinations%20Report%20US%20and%20by%20State%20Nov%2017%20Revised.pdf>.

³⁸ See, e.g., Christina Maxouris, *December Is the Deadliest Month in the US Since the Coronavirus Pandemic Began—and Projections for January Are “Nightmarish,” Expert Says*, CNN Health (Dec. 27, 2020), <https://cnn.it/3oO1BKX>.

before or since.³⁹ While vaccination rates will hopefully suppress this year’s holiday surge, the highly transmissible Delta variant, and the newly discovered Omicron variant, create a significant risk of another major spike.⁴⁰ As former FDA Commissioner Scott Gottlieb put it, “We’re going to see a post-holiday spike, there’s no question about that. People are exhausted right now, but we need to remain vigilant just for a little bit longer.”⁴¹

III. Masks Do Not Harm Children

The State suggests that the “broad injunction that Plaintiffs seek,” which would allow school districts to implement universal mask policies, “would harm the parents and students who do not want masks forced upon students.” Appellant Br. at 14. To the extent that the “harm” to which the State refers encompasses the idea that masks are somehow harmful to children’s emotional well-being or development, the medical literature suggests otherwise. While such fears are understandable, the AAP’s comprehensive review of the medical research has shown that they are unfounded.

There is currently “no evidence that use of face masks prevents or delays speech or language development.”⁴² Not being able to see part of a person’s face is not a significant impediment to social and speech development—as the experience of children who are blind from birth confirms. “[V]isually impaired children develop speech and language skills at the

³⁹ *Weekly Updates by Select Demographic and Geographic Characteristics*, CDC (data available as of Nov. 10, 2021), <https://bit.ly/3wLRp9f>.

⁴⁰ See, e.g., Jackie Salo, *Former FDA Head Warns of Post-Thanksgiving Spike in COVID-19 Cases*, N.Y. Post (Nov. 14, 2021), <https://bit.ly/30AlQ6t>.

⁴¹ *Id.*

⁴² *Do Masks Delay Speech and Language Development?*, AAP, <https://healthychildren.org/English/health-issues/conditions/COVID-19/Pages/Do-face-masks-interfere-with-language-development.aspx>.

same rate as their peers.”⁴³ Indeed, being unable to see speakers’ mouths for a portion of the day may help children use other clues to understand and learn language and non-verbal communication, such as gestures, changes in tone of voice, and the like.⁴⁴

In addition, the research demonstrates that mask-wearing is not linked to emotional or psychological harm, particularly when caregivers promote positive associations around mask-wearing.⁴⁵ While children can develop secondary anxieties about wearing a mask, this is no different from the possibility of developing secondary anxieties about eating, attending school, or any other activity. The risk of developing secondary anxiety or disordered behavior related to masking may be especially high when parents or community members perpetuate false claims that masks are harmful. But there is nothing intrinsic about mask-wearing that makes it particularly harmful, whether physically, socially, or emotionally.

⁴³ *Id.*

⁴⁴ *Id.*; see also Ashley L. Ruba & Seth D. Pollak, *Children’s emotion inferences from masked faces: Implications for social interactions during COVID-19*, PLoS One (2020), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0243708> (finding that “while there may be some challenges for children incurred by others wearing masks, in combination with other contextual cues, masks are unlikely to dramatically impair children’s social interactions in their everyday lives”).

⁴⁵ *Interim Guidance on Supporting the Emotional and Behavioral Health Needs of Children, Adolescents, and Families During the COVID-19 Pandemic*, supra n. 17; *Face Masks*, supra n. 18 (providing recommendations for “help[ing] my child get used to wearing a mask”); *Supporting your child’s mental health during COVID-19 school returns*, UNICEF (Aug. 28, 2020), <https://www.unicef.org/coronavirus/supporting-yourchilds-mental-health-duringcovid-19-school-return> (“Approach this conversation with empathy, saying that you know she is feeling anxious about coronavirus, but that it’s healthy to talk about our worries and emotions. Children may also get upset or frustrated if they are finding it hard to wear masks, especially when running or playing. You can reassure your children that lots of adults are working hard to help keep your family safe, but emphasize that it’s important we all follow the recommended measures to take care of more vulnerable members of our community.”).

In sum, the fears associated with universal mask policies in schools have no basis in scientific research or medical experience. The “public consequences” of reversing the court below thus weigh heavily against vacating the injunction. *See Winter*, 555 U.S. at 24.

IV. Prohibiting Schools from Requiring Masks Does Not Further Any Legitimate State Purpose.

Given the devastating threat posed by the COVID-19 pandemic and the overwhelming scientific consensus that universal mask policies are a safe and effective way to reduce its spread, there is no compelling or even rational and legitimate state purpose in the State’s bill prohibiting schools from adopting universal mask policies, nor in prohibiting public schools from requiring masks while allowing private schools to do so. Whatever the interest a state has in protecting “the liberty of parents and guardians to direct the upbringing and education of children,” Appellant Br. at 7, parental rights do not “include the liberty to expose the community or the child to communicable disease or the latter to ill health or death.” *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944). “Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.” *Id.* at 170.

While parents have a right to make many decisions concerning the education of their children, they do not have the right to demand access to schools in a way that places the lives and health of other children (as well as teachers, school staff, and the broader community) at risk. As explained above, the presence of unmasked children in school significantly increases the risk that even masked children will contract COVID-19. There is no parental right to expose other children to virulent communicable diseases. The sole putative interest that the State asserts is thus insubstantial.

CONCLUSION

For these reasons, the Court should affirm the injunction issued below, but should modify it, as requested by Appellees, to remove the opt-out provision grafted from the State's vaccination and exemption statutes. Doing so would enable school districts, when medically recommended, to implement universal mask policies that would protect school-age children from the risk of grave illness.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 3rd day of December, 2021, a true and correct copy of the
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