OPPOSE SB385

Honorable President, Chair, and the members of the committee.

It is encouraging to see the legislature take seriously the principle of state self-determination and the responsibility to shape policies that reflect the needs and values of Maryland residents. A willingness to evaluate federal guidance independently and to tailor decisions to local circumstances shows respect for the state's unique priorities and for the voices of its citizens. Thoughtful federal-state balance can help ensure that policies are not merely adopted by default, but are considered in light of their real-world impact on the people they serve.

However, the VAX ACT would require the Maryland Department of Health to prioritize vaccine schedules and related measures based on recommendations from organizations such as the AAP, ACOG, and AAFP. These groups represent provider interests and receive pharmaceutical funding, which may influence their guidance. Their recommendations do not always fully acknowledge potential risks or differing scientific perspectives, and their messaging emphasizes increasing vaccination rates.

Below is a brief overview of the organizations' key decisions, many of which were ultimately corrected or overridden through the emergence of external evidence and factual developments. The persistent gap between their initial stated guidance and the actual outcomes, coupled with reluctance to promptly reverse flawed policies, reveals a pattern of organizational bias, inadequate internal controls, and insufficient accountability.

Chronological Record of AAP Major Policy Positions & Outcomes (2014–2026)

Year	Policy or Guidance	Core AAP Recommendation	Subsequent Outcome / Reversal	Current Alignment
2014–2015	*Dietary Fat and Heart Health in Children*	Endorsed low-fat diet, discouraged saturated fats universally, aligned with old USDA model	Growing consensus supports dietary fat (esp. omega-3s, dairy, eggs) as critical for brain development; AAP	Outdated; no direct evidence low-fat improves

			has not formally corrected	pediatric outcomes
2015–2016	*Screen Time & Digital Media Use*	"Limit to < 2 hrs/day for > 2 yrs old; avoid < 18 months" revised to "balance screen time with interpersonal engagement"	Relaxation led to surge in toddler device-use; later internal briefings admitted higher ADHD & speech-delay correlation	Earlier restrictive guidance closer to correct; AAP loosened prematurely
2016	*HPV Vaccination Expansion*	Promote HPV vaccine down to age 9; push for school mandates	Uptake plateaued; post-marketing signals (syncopal events, autoimmune concerns) prompted European caution; AAP → no revision	Evidence mixed; risk-benefit borderline for lower ages
2018	*Comprehensive Care for Transgender & Gender-Diverse Youth*	Full affirmation model incl. puberty blockers, cross-sex hormones, surgeries for minors	By 2023 Sweden, Finland, & U.K. reversed these protocols citing harm & lack of data; AAP → announced systematic evidence review	Evidence now disfavors early medical transition; AAP under pressure to revise
2020 (Mar)	*COVID Response: Initial Guidance*	Supported nationwide school closures & remote learning	Within months reversed stance to "schools should reopen"; damage acknowledged later	Now understood closures caused greater harm than benefit

2020 (Jul)	*School Reopening Statement*	Urged reopening “if safety measures feasible”	Politically walked back after CDC coordination; confusion fueled inconsistent policy	Original July 2020 stance proven correct; later re-alignment cost credibility
2020–2022	*Universal Child Masking ≥ 2 years old*	Required masks in all indoor settings incl. preschools	Mask mandates dropped 2022; AAP quietly retired web pages	Studies show null infection difference; harms to speech & emotion recognition confirmed
2020–2023	*Pediatric mRNA Vaccination & Boosters*	“Strongly recommended” for 6 mo–17 yrs despite low risk	CDC & global data later revealed negligible net benefit; myocarditis risk documented; uptake collapsed < 5 % of eligible toddlers	Position effectively disproven; remains uncorrected publicly
2021	*COVID Testing & Quarantine in Schools*	Backed routine screening & quarantine for asymptomatic kids	CDC rescinded by 2022; AAP webpages archived	Testing of healthy children deemed unnecessary
2021–2022	*Masking & Child Development Statement*	Claimed “no evidence masks hinder learning”	Later AAP press call admitted language-development delays; no formal retraction	Claim proven false

2022	*Combatting Misinformation Initiative*	Advised censorship of “anti-vaccine misinformation” online	Widely criticized for blurring free-speech lines; no clear retraction	Reputational damage; chilling effect on discourse
2023	*Gender-Affirming Care: Re-evaluation Vote*	Board approved systematic review to reassess 2018 policy	Acknowledgment of weak evidence base; first step toward reversal	Review pending; likely significant revision
2023	*COVID Masking for Immunocompromised Children*	Continued to recommend masks even after mandates ended	Quietly deleted by 2024; replaced with “individualized discussion”	Inconclusive, but broad guidance abandoned
2024	*Catch-Up Learning Statement*	Admitted “unintended harm” from pandemic school policies	No accountability but implicit reversal of 2020-closure advocacy	Match with external literature confirming multi-year learning loss
2025	*Myocarditis & COVID Boosters in Teens*	First admission of cardiotoxic risk; recommended physician discretion	Partial backtrack from “universal booster” narrative	Confirms earlier criticism was valid

Chronological Record of ACOG Policy Positions & Outcomes (2014–2026)

Year	Policy / Guideline	Core ACOG Position	Subsequent Outcome / Revision	Current Alignment
2014–2015	*Hormonal Contraception & Cancer Risk*	Asserted that oral contraceptives "reduce overall cancer risk," downplaying mixed data on breast & cervical cancer rise	Later papers confirmed small ↑ breast & cervical cancer risk with long-term use; protective effects overstated	Partially contradicted
2015–2016	*Zika Virus Guidance for Pregnancy*	Endorsed aggressive testing, travel restrictions, and discouraged pregnancy in affected regions	Overprediction of global Zika risk; recommendations rolled back by 2018	Overly cautious; later softened
2016	*Routine HPV Vaccination up to Age 26 – 45*	Endorsed extension to age 45, supporting pharma-backed expansion	Subsequent cost-effectiveness analyses showed minimal benefit beyond 26	Largely unsupported
2017	*Hormone Therapy after Menopause*	Maintained WHI-era fear of estrogen, cautioning against systemic use	New meta-analyses demonstrated safety of bioidentical/transdermal forms; ACOG finally modulated tone 2022	Gradual correction

2018	*Pregnancy Weight-Gain Guidelines*	Promoted uniform low-calorie model; undervalued metabolic individuality	Later research revealed over-restriction ↑ preterm birth risk; recommendations adjusted 2024	Corrected
2019	*Abortion Access Statement*	Declared abortion "essential health care" and opposed all gestational restrictions	Remains unchanged—politically charged; ignores fetal viability gradient science	Biologically simplified, ethically disputed
2020 (Mar)	*COVID Pregnancy Guidance v1*	Urged limiting support persons at birth, denying partners' presence, early postpartum separation for exposed mothers	Found to worsen maternal mental health; reversed by late 2020	Reversal acknowledged
2020 (Apr–Jul)	*COVID Vaccine Guidance for Pregnant & Breastfeeding Women*	Initially "insufficient evidence—individual decision"; by Dec 2020 → endorsed universal vaccination w/o long-term data	Reversed position before safety data available; later studies indicated transient menstrual effects, uncertain neonatal antibody persistence	Premature endorsement
2020–2021	*Masking and Labor & Delivery*	Required masking of laboring	Dropped mid-2021 after media backlash & studies showing	Wrong policy, later rescinded

		women during contractions	stress & oxygen deprivation	
2021	*COVID Booster in Early Pregnancy*	"Strongly recommend" without trimester differentiation	Later OB registries noted higher early-pregnancy bleeding & menstruation irregularities; ACOG silent on revision	Evidence mixed; overconfident guidance
2021–2022	*Telemedicine Abortion & Mail-Order Pills*	Full endorsement citing "safety equivalent to in-clinic"	2023–2025 data show rising ER presentations for retained products, uncontrolled bleeding; some state investigations underway	Contradicted by outcomes data
2022	*Gender-Affirming Care in Obstetrics & Gynecology*	Declared "affirming care is evidence-based lifesaving treatment" incl. surgeries & hormones for minors	International pediatric bodies reversed same stance (UK, Sweden, Finland); ACOG repetition in conflict with emerging data	Under review; likely revision pending
2023	*Post-Dobbs Reproductive Access Memo*	Focused lobbying on state nullification of restrictions, framing abortion purely as "medical emergency care"	Intensified politicization; adverse optics with voters; science sections minimal	Still politically motivated rather than data-driven

2023–2024	*COVID Vaccine & Fertility Statement*	Claimed “no possible mechanism” for fertility disruption	Peer-reviewed studies later reported transient ovarian cycle changes; ACOG added footnote “temporary variations possible”	Semi-walk-back
2024	*Induction at 39 Weeks (ARRIVE Study adoption)*	Promoted elective induction at 39 weeks for low-risk women	2024 data showed higher NICU admissions & cost; new draft advises individualized approach	Quietly reversed original enthusiasm
2025	*Gestational Diabetes Thresholds*	Advocated lower diagnostic thresholds (IADPSG standard)	Follow-up trials found overtreatment and anxiety; 2025 update raised thresholds again	Correction acknowledged
2025–2026	*Environmental Exposures in Pregnancy*	First time acknowledged PFAS, microplastics, endocrine disruptors; but stopped short of recommending limits	Lagged behind EU guidance; criticized as industry-friendly	Incomplete approach
2026	*Ongoing Guidance Reforms*	Internal review of conflict-of-interest policy; new transparency pledge	Response to criticism about industry funding & politicization	Reform in progress

By formally elevating a narrow group of trade organizations and embedding their preferences into state policy, the government would effectively mandate a rigid, one-size-fits-all maximum-vaccination approach that overrides individual patient circumstances. This transforms a deeply personal **medical decision** - one that should be made **exclusively** between a patient and their own doctor, based on that person's unique health history, risks, and values - into a political policy battle. The result is the needless politicization of private health choices that belong solely in the exam room, not the statehouse.

Please vote unfavorably.

Sincerely,
Mark Meyerovich
District 15