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AARON KHERIATY, M.D.

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

AARON KHERIATY, M.D., Plaintiff, v. TOMAS J. ARAGON, in his official capacity as Director of the The California Department of Public Health, Defendant.	Case No. **COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF**

Plaintiff, AARON KHERIATY, M.D. ("**Plaintiff**") for his verified complaint, against TOMAS J. ARAGON, in his official capacity as Director of the California Department of Public Health ("**CDPH**" or "**Defendant**") by and through his attorneys, alleges as follows:

INTRODUCTION

1. The equal protection clause of the Fourteenth Amendment to the U.S. Constitution requires a state to treat an individual in the same manner as others in similar conditions and circumstances. The Fourteenth Amendment further recognizes and guarantees fundamental rights and liberty interests of personal autonomy and bodily integrity. Plaintiff brings this action because the California Department of Public Health ("**CDPH**") will soon require that he is vaccinated for COVID-19 in order to work and provide services at his hospital, University of California Irvine, and is thereby violating his liberty interests and treating him differently from other similarly situated individuals who are permitted to work at the health care facility.

2. Over the eons of human development, our bodies have created a remarkable immune system capable of protecting us against a wide variety of pathogenic viruses. This system includes an enormously diverse repertoire of cells with a nearly unlimited capacity to recognize and 'adapt' to previously unseen viruses. Rather than having to re-create the same immunological response every time a virus attacks the body, our immune

systems have an innate form of memory which prevents reinfection with the same virus. This memory system creates antibodies to all antigens of a given virus thereby providing previously infected individuals with neutralizing immunity to a previously encountered virus ("naturally immune individuals").

3. While different vaccines for COVID-19 work in different ways, they are all designed to create immunity to a portion of the virus (specifically, the spike protein), without creating too many side effects, in the hope that this partial immunity to a portion of the virus will confer neutralizing immunity to the entire virus when encountered by the vaccinated individual. Despite humanity's best efforts at mimicking the immune system's protection, the immunity generated after infection with a virus, including SARS-CoV-2 (the virus which causes the disease COVID-19, hereinafter the "virus" or the "COVID-19 virus"), creates a more robust and durable form of immunity to a virus than any vaccine can create.

4. Recent studies related to COVID-19 vaccines demonstrate these weaknesses in vaccine-induced immunity. While someone who has had the COVID-19 virus will typically immediately neutralize the virus upon re-exposure, thereby preventing reinfection and transmission, studies have found that an individual vaccinated for COVID-19 can still become infected with and have the same amount of virus in their nasopharynx as an unvaccinated individual with COVID-19. The vaccinated individual should typically have fewer symptoms, however that individual can still transmit the virus to others.

5. CDPH enacted a State Public Heath Officer Order on August 5, 2021 "in order to prevent [COVID-19's] further spread in hospitals, SNFs [skilled nursing facilities], and other health care settings" by ensuring that individuals who provide services or work in these facilities have immunity to the virus that causes COVID-19 (the "Mandate"). However, to reach this goal, CDPH decided that only vaccinated individuals will be permitted to work at or provide services at the facilities come this fall, ignoring

those who have natural immunity to the virus. Thus, the Mandate provides that "[a]ll workers who provide services or work in [enumerated health care] facilities have their first dose of a one-dose regimen or their second dose of a two-dose regimen by September 30, 2021." In enacting this Mandate, the CDPH is treating naturally immune individuals differently from individuals whose immunity was created by one of the COVID-19 vaccines.

6. Plaintiff is a physician and professor of Psychiatry and Human Behavior at the UCI School of Medicine with hospital privileges at UCI Health ("**UCI**"). He is one of the estimated 4.5 million Californians[1] who are confirmed to have contracted the COVID-19 virus. He was infected with the virus in July 2020 and experienced many of the common symptoms associated with COVID-19, including a cough and loss of taste and smell. In fighting off the virus, his body created a robust natural immunity to every antigen on the COVID-19 virus, not just the spike protein of the virus as happens with the COVID-19 vaccines. Nevertheless, CDPH requires Plaintiff to receive a COVID-19 vaccine in order to continue his work at UCI. Thus, CDPH is treating him differently by refusing to allow him to work at UCI when other individuals who are considered immune to the virus are being admitted back simply because their immunity was created by a vaccine. This policy is illogical and cannot withstand strict scrutiny or even a rational basis test because naturally immune individuals, like Plaintiff, have at least as good or better immunity to the virus that causes COVID-19 than do individuals who are vaccinated.

7. In the 21 months that the world has been transfixed by the COVID-19 pandemic, evidence shows that the reinfection rate after natural infection is less than 1%, and there are no documented cases of reinfection and transmission to others by naturally immune individuals. In contrast, COVID-19 vaccination in the optimal setting of a

[1] *See* https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/nCOV2019.aspx.

clinical trial has, at best, an estimated 67% to 95% efficacy (depending on the COVID-19 vaccine and the variant of the virus) and the vaccine manufacturers and public health agencies have made clear that booster doses will likely be needed, due to waning immunity created by the vaccines. Likewise, recent United States Centers for Disease Control and Prevention ("**CDC**") studies have been replete with reports of so-called "breakthrough cases" where individuals are infected after they are fully vaccinated. Dr. Rochelle Walensky, Director of the CDC, and Dr. Anthony Fauci, Director of NIH's NIAID, have explained that the amount of virus in those individuals' noses is the same as the unvaccinated who have COVID-19.[2] This has led to the CDC's revised guidelines recommending a return to masks for those who have been vaccinated and experts to conclude that "vaccination is now about personal protection" because "herd immunity is not relevant as we are seeing plenty of evidence of repeat and breakthrough infections."[3]

8. As described more fully herein, CDPH's refusal to allow Plaintiff to work at UCI until he receives a vaccine is an equal protection violation. The right of individuals to their bodily integrity, which includes a right to refuse medical treatment, has long been recognized as one of the fundamental liberty rights afforded under due process. By forcing Plaintiff to receive a vaccine he does not want or need, and that may cause harm, in order to be treated equally as other individuals who are also immune, CDPH's Mandate implicates Plaintiff's substantive due process rights, and the Court should analyze his equal protection claim under the strict scrutiny analysis, i.e., whether the Mandate is both satisfying a compelling government need and is implemented by the least restrictive means. Defendant cannot satisfy either of these prongs. Even though a

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[2] *See* https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm?s_cid=mm7031e2_w#contribAff; *see also* https://www.msnbc.com/all-in/watch/dr-fauci-explains-updated-cdc-mask-guidance-for-vaccinated-people-amid-covid-hotspots-117489221538 at 1:09; *see also* https://www.nytimes.com/2021/07/30/health/covid-cdc-delta-masks.html?smtyp=cur&smid=tw-nytimes.

[3] *See* https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html; *see also* https://www.washingtonpost.com/health/2021/07/29/cdc-mask-guidance/.

government entity has a compelling government interest in preventing the spread of COVID-19, that interest is not furthered by compelling Plaintiff to be vaccinated to satisfy this interest because he is already naturally immune and, unlike the vaccinated, if exposed to the virus, has neutralizing immunity. By failing to acknowledge that naturally immune individuals are unlikely to spread the virus, and certainly far less likely than the vaccinated, the Mandate is not narrowly tailored.

9. Nor can the Mandate even satisfy rational basis analysis. Plaintiff is already naturally immune to the virus. He is therefore less likely to infect other individuals than are people who have been vaccinated. As a result, requiring him to be vaccinated in order to work at his health care facility is irrational. In addition, by targeting people who have had the virus but remain unvaccinated, the Mandate unfairly singles out one unpopular group for disparate treatment.

10. For these reasons, more fully explained below, Plaintiff seeks an injunction and declaratory relief enjoining Defendant from enforcing the Mandate against him or any other naturally immune individual.

PARTIES

11. Plaintiff, AARON KHERIATY, M.D., is an individual who resides in Orange County, California. Plaintiff is currently employed at the University of California, Irvine, School of Medicine and has hospital privileges at UCI Health.

12. Defendant TOMAS J. ARAGON is the Director and State Public Health Officer of the California Department of Public Health. Defendant Aragon is responsible for the implementation, and enforcement, of the challenged policy, and, since its enactment, has directed, implemented, and enforced the policy. Defendant Aragon is responsible for enforcing, has enforced, and will continue to enforce in the future, the challenged mandate against Plaintiff, as further explained herein.

JURISDICTION AND VENUE

13. This Court has subject-matter jurisdiction over this action under 28 U.S.C. §§ 1331 and 1343(a).

14. Venue is proper in this judicial district under 28 U.S.C. § 1391 because Defendant conducts business in this judicial district and a substantial part of the events or omissions giving rise to this action occurred in this judicial district.

FACTUAL BACKGROUND

I. PLAINTIFF HAD COVID-19

15. Plaintiff is a professor of Psychiatry and Human Behavior at the UCI School of Medicine and the director of the Medical Ethics Program at UCI Health. UCI Health is a health care facility, and more specifically, a general acute care hospital. As a School of Medicine employee, Plaintiff has hospital privileges at UCI Health.

16. Plaintiff contracted the COVID-19 virus in July 2020, which was confirmed by PCR testing, and he experienced many of the common symptoms associated with COVID-19, including loss of taste and smell. Plaintiff fully recovered.

II. COVID-19 IN CALIFORNIA AND FAILED RESTRICTIVE MEASURES

17. The first confirmed case of the COVID-19 virus in California was on January 22, 2020.[4] Governor Gavin Newsom ("**Newsom**") instituted aggressive stay at home orders in California on March 19, 2020, when there were approximately 900 cases within the state.[5] Despite the aggressive stay at home orders, the virus continued to spread.

18. The CDC has explained that even with protective measures as instituted in California, "most of the U.S. population will be exposed to this virus [SARS-CoV-2]."[6]

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[4] *See* https://www.latimes.com/world-nation/story/2020-08-21/surprising-tale-first-la-covid-19-case.

[5] *See* https://www.politico.com/states/f/?id=00000170-f5a4-d209-af70-fdae4c930000; *see also* https://www.ksla.com/2020/03/20/california-becomes-first-state-order-lockdown/.

[6] https://stacks.cdc.gov/view/cdc/86068/cdc_86068_DS1.pdf.

The CDC estimates that, through May 2021, approximately 49% of those aged 18 to 49 years have been infected with SARS-CoV-2 despite lockdowns. This means that a large percentage of the individuals subject to the Mandate are likely to have already had the virus and have natural immunity and, as discussed herein, have a lower risk than vaccinated individuals of being re-infected with and transmitting the virus.

19. If Defendant instituted the Mandate with the goal of having health care professionals that are immune to the COVID-19 virus, it would have exempted from the Mandate those who are already immune due to having had COVID-19. Failure to do so means that Defendant's Mandate is not about immunity, it is only about vaccination status.

III. PLAINTIFF HAS A LOWER RISK OF BECOMING RE-INFECTED AND TRANSMITTING THE VIRUS THAN VACCINATED INDIVIDUALS

20. The peer reviewed literature and data reflect that those previously infected with Covid-19 (the "**naturally immune**") have superior protection from becoming infected with and transmitting SARS-CoV-2 than those vaccinated for Covid-19 (the "**vaccine immune**"). Critically:

a. All major studies reviewing this issue, which collectively have reviewed hundreds of thousands of naturally immune versus vaccine immune individuals, found that the rate of infection among the naturally immune ("**reinfections**") is far lower than the rate among the vaccinated ("**breakthrough cases**").

b. Despite a world-wide hunt, there has never been a single documented case of reinfection resulting in further transmission, while, in contrast, there are numerous documented cases of breakthrough cases resulting in further transmission.

c. Over a dozen major studies have found that, consistent with the real-word data, the naturally immune have more robust and durable T cell and B cell immunity.

21. These three facts alone should suffice to lift restrictions on the naturally immune at least to the same extent as the vaccine immune.

A. Reinfections v. Breakthrough Cases

22. UK's official government COVID-19 data shows a **probable reinfection rate** of **0.025%** through August 19, 2021 during Delta.[7] In contrast, this same data shows, through September 2, 2021, a **vaccine breakthrough rate** for Delta infections of **23%**.[8] **This is in line with** statement by the Director of the CDC, **Dr.** Rachel **Walensky**, **that, "A modest percentage of people who are fully vaccinated will still get COVID-19 if they are exposed to the virus that causes it."**[9]

23. All major studies looking at this issue are consistent with the UK data and confirm that reinfections are exceedingly rare as well as confirm the durability of natural immunity:

a. The Cleveland Clinic measured cumulative incidence of SARS-CoV-2 infection among 52,238 vaccinated and unvaccinated health care workers over a five-month period and found that none of the 1,359 previously infected who remained *unvaccinated* contracted SARS-CoV-2 over the

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[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1012240/Weekly_Flu_and_COVID-19_report_w33.pdf at 17-18.

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1014926/Technical_Briefing_22_21_09_02.pdf at 21. Meanwhile, the CDC – which is only reporting breakthrough cases which lead to hospitalization and death and whose "surveillance relies on passive and voluntary reporting" and acknowledges that "data are not complete or representative" and "are an undercount of all SARS-CoV-2 infections among fully vaccinated persons – has reported 14,115 breakthrough cases; https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html. Notably, Louisiana alone had counted 14,650 breakthrough infections as of August 25, 2021, https://www.politico.com/news/2021/08/25/cdc-pandemic-limited-data-breakthroughs-506823.

[9] https://www.nytimes.com/article/covid-breakthrough-delta-variant.html.

course of the research despite a high background rate of COVID-19 in the hospital.[10]

b. Researchers from Ireland conducted a review of 11 cohort studies involving over 600,000 total recovered COVID-19 patients who were followed up with for over 10 months and found that that reinfection in all studies was "an uncommon event" and explained that there was "**no study reporting an increase in the risk of reinfection over time**."[11]

c. Researchers from Qatar analyzed the population-level risk of reinfection based on whole genome sequencing, tracking 43,044 individuals for up to 35 weeks, and found that just .02% experienced reinfection (an estimated risk of reinfection of 0.66 per 10,000 person-weeks). Notably, there was no evidence of waning immunity during the over seven-month follow-up period.[12]

24. On the other hand, all major studies comparing the rate of breakthrough cases with reinfections have found that breakthrough cases are multiple times higher than the rate of reinfections:

a. A comparison of 42,000 naturally immune individuals with 62,000 fully vaccinated individuals found that the fully vaccinated individuals were **6 to 13 times more likely to get infected than the naturally immune**.[13]

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[10] Nabin K. Shrestha, Et Al., *Necessity Of Covid-19 Vaccination In Previously Infected Individuals*, Medrxiv (June 19, 2021) https://Www.Medrxiv.Org/Content/10.1101/2021.06.01.21258176v3.

[11] Eamon Murchu, et al., *Quantifying the risk of SARS-CoV-2 reinfection over time*, Reviews of Medical Virology (May 27, 2201) https://pubmed.ncbi.nlm.nih.gov/34043841/.

[12] Laith J. Abu-Raddad, et al., *SARS-CoV-2 antibody-positivity protects against reinfection for at least seven months with 95% efficacy*, EClinical Medicine (April 28, 2021) https://pubmed.ncbi.nlm.nih.gov/33937733/.

[13] Sivan Gazit, et al., *Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections*, medRxiv (August 25, 2021) https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1.

Additionally, **the risk of symptomatic COVID-19 was 27 times higher among those vaccinated than those previously infected** and the risk of hospitalization was 8 times higher.[14] The study concluded that, "natural immunity confers longer lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 [Pfizer] two-dose vaccine-induced immunity."[15]

b. The Israeli Health Ministry found that the vaccinated had 6.72 times the rate of infection as compared to those that had contracted COVID-19:

> With a total of 835,792 Israelis known to have recovered from the virus, the 72 instances of reinfection amount to 0.0086% of people who were already infected with COVID.
>
> By contrast, Israelis who were vaccinated were 6.72 times more likely to get infected after the shot than after natural infection.[16]

c. A nation-wide study of over 6 million individuals in Israel found that vaccine immunity had an efficacy of 92.8% for documented infection, 94.2% for hospitalization, and 94.4% for severe illness, but that the naturally immune had a higher rate of protection in all three of these categories.[17]

d. An outbreak of SARS-CoV-2 infected 24/44 (55%) employees of a gold mine in French Guiana. The attack rate was 15/25 (60.0%) in fully

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[14] *Id.*

[15] *Id.*

[16] https://www.israelnationalnews.com/News/News.aspx/309762.

[17] Yair Goldberg, Et Al., *Protection Of Previous Sars-Cov-2 Infection Is Similar To That Of Bnt162b2 Vaccine Protection: A Three-Month Nationwide Experience From Israel*, Medrxiv (April 24, 2021) https://Www.Medrxiv.Org/Content/10.1101/2021.04.20.21255670v1.

> vaccinated miners, 6/15 (40.0%) in those partially vaccinated or with a history of COVID-19 (none of the partially vaccinated with a history of COVD-19 were positive), and 3/4 (75%) in those not vaccinated. The attack rate was 0/6 among persons with a previous history of COVID-19 versus 63.2% among those with no previous history.[18]

25. Moreover, while the risk of reinfection has not increased over time (see studies cited above), the risk of breakthrough infections is increasing over time. This is because the protection from natural immunity remains stable whereas vaccine immunity is rapidly waning.

26. A Mayo Clinic study looked at the efficacy of COVID-19 vaccines from January to July 2021, during which either the Alpha or Delta variant was highly prevalent.[19] The results showed that as of July, the efficacy of Moderna's vaccine had dropped to 76% and the efficacy of Pfizer's vaccine dropped to 42%.[20] This is consistent with Pfizer's data which demonstrates that the efficacy of its vaccine falls by about 6 percent every two months (with data only through "up to 6 months").[21] As Pfizer's CEO publicly acknowledged, the efficacy after "four to six months was approximately 84%."[22] A drop of 6% per months means an efficacy of around 60% by one year and around 42% by 18 months, assuming the decline continues linearly rather than, as often happens, exponentially. This waning immunity is also apparent in Israel which has higher and

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[18] *Nicolas Vignier, et al.* Breakthrough Infections of SARS-CoV-2 Gamma Variant in Fully Vaccinated Gold Miners, French Guiana, 2021*, Emerging Infectious Diseases (July 21, 2021)* https://pubmed.ncbi.nlm.nih.gov/34289335/.

[19] Arjun Puranik, et al., *Comparison of two highly-effective mRNA vaccines for COVID-19 during periods of Alpha and Delta variant prevalence*, medRxiv (August 21, 2021) https://pubmed.ncbi.nlm.nih.gov/34401884/.

[20] *Id.*

[21] Stephen J. Thomas, et al., *Six Month Safety and Efficacy of the BNT162b2 mRNA COVID-19 Vaccine*, medRxiv (July 28, 2021) https://www.medrxiv.org/content/10.1101/2021.07.28.21261159v1.full.pdf.

[22] https://www.cnbc.com/2021/07/28/pfizers-ceo-says-covid-vaccine-effectiveness-drops-to-84percent-after-six-months.html.

earlier vaccination coverage and, as of August 10, 2021 "Health Ministry data … showed that fully vaccinated individuals were responsible for most new cases and most of those hospitalized in moderate condition or worse."[23]

27. That natural immunity is more durable than vaccine immunity should not be surprising.[24] Vaccine immunity has never proven more durable than natural immunity for any vaccine.[25] Even directly after vaccination, natural immunity is plainly superior to vaccine immunity. Pfizer's interim clinical trial results, for example, demonstrate 95% effectiveness after two months in preventing symptomatic COVID-19 in those who have not been previously infected.[26] Moderna's interim clinical trial results demonstrate 94.1% effectiveness after two months in preventing symptomatic COVID-19 in those who have not been previously infected.[27] Even in these ideal, controlled situations, against the Alpha variant, the two mRNA vaccines have a significant gap in efficacy in preventing disease at any point in time, while the consistent and unrebutted data on natural immunity reflects greater than 99% efficacy against reinfection which has remained stable over time in all studies assessing same.[28]

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[23] https://www.timesofisrael.com/over-5000-new-coronavirus-cases-confirmed-monday-as-new-limits-mulled/.

[24] *See, e.g.,* Plotkin's Vaccines, 7th Edition, at Section 2.

[25] *Id.*

[26] Sara E. Oliver, Et Al., *The Advisory Committee On Immunization Practices' Interim Recommendation For Use Of Pfizer-Biontech Covid-19 Vaccine - United States, December 2020*, Mmwr Morb Mortal Wkly Rep (December 18, 2020) https://Pubmed.Ncbi.Nlm.Nih.Gov/33332292/.

[27] Arjun Puranik, et al., *Comparison of two highly-effective mRNA vaccines for COVID-19 during periods of Alpha and Delta variant prevalence*, medRxiv (August 21, 2021) https://pubmed.ncbi.nlm.nih.gov/34401884/.

[28] *See* studies cited in Section I *supra*. It is also noteworthy that SARS-CoV-2 is at least 80% homologous to SARS-CoV-1 at the epitopes that would be recognized by host defenses that confer immunity, and the major antigen in SARS-CoV-2 is the nucleocapsid and this has greater than 90% homology to SARS-CoV-1. (Jiabao Xu, et al. *Systematic Comparison of Two Animal-to-Human Transmitted Human Coronaviruses: SARS-CoV-2 and SARS-CoV*, Viruses (February 22, 2020)

B. Sterilizing Immunity v. Non-Sterilizing Immunity

28. The data and studies also reflect that natural immunity provides sterilizing immunity while vaccination does not provide sterilizing immunity.

29. The clinical trial's primary endpoint for the COVID-19 vaccines is measuring effectiveness against disease – not against infection.[29] Once used in the real-world, as Dr. Walensky has acknowledged, they do not "prevent infection or transmission."[30] This is also confirmed by various studies, including:

a. COVID-19 vaccines could *not* fully block viral infection and replication in the nose of monkeys upon viral challenge.[31] In contrast, SARS-CoV-2 infection of monkeys completely prevented further re-infection at any site tested – by nasal, throat, and anal swabs.[32]

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https://pubmed.ncbi.nlm.nih.gov/32098422/.) The immunity to SARS-CoV-1 has been lifelong over the observation period thus far in humans which is 17 years reflecting the duration of immunity that is likely from SARS-CoV-2. (Nina Le Bert, et al., *SARS-CoV-2-specific T cell immunity in cases of COVID-19 and SARS, and uninfected controls*, Nature (July 15, 2020) https://pubmed.ncbi.nlm.nih.gov/32668444/; Jianmin Zuo, et al., *Robust SARS-CoV-2-specific T cell immunity is maintained at 6 months following primary infection,* Nat Immunol (March 5, 2021) https://pubmed.ncbi.nlm.nih.gov/33674800/).

[29] Sara E. Oliver, et al., *The Advisory Committee on Immunization Practices' Interim Recommendation for Use of Pfizer-BioNTech COVID-19 Vaccine - United States, December 2020* MMWR Morb Mortal Wkly Rep (December 18, 2020) https://pubmed.ncbi.nlm.nih.gov/33332292/.

[30] https://twitter.com/CNNSitRoom/status/1423422301882748929.

[31] Kizzmekia S. Corbett, Ph.D, et al., *Evaluation of the mRNA-1273 Vaccine against SARS-CoV-2 in Nonhuman Primates*, N Engl J Med (July 28, 2020) https://pubmed.ncbi.nlm.nih.gov/32722908/. Van Doremalen N. et al., *ChAdOx1 nCoV-19 vaccination prevents SARS-CoV-2 pneumonia in rhesus macaques*, Nature (July 30, 2020) https://pubmed.ncbi.nlm.nih.gov/32731258/.

[32] Wei Deng, Et Al., *Primary Exposure To Sars-Cov-2 Protects Against Reinfection In Rhesus Macaques*, Science (August 14, 2020) Https://Pubmed.Ncbi.Nlm.Nih.Gov/32616673/.

b. In Barnstable County, Massachusetts, which has a 69% vaccination coverage rate among its eligible residents, the CDC found that 74% of those infected in an outbreak were fully vaccinated for COVID-19 and that the vaccinated had on average more virus in their nose than the unvaccinated that were infected.[33]

c. A study of transmission among fully vaccinated health care workers in Vietnam found "transmission between the vaccinated people" and therefore concluded that "distancing measures remain critical to reduce SARS-CoV-2 Delta variant transmission" among the vaccinated.[34]

d. French researchers tested blood samples from health care workers who were COVID-19 naïve and received two doses of Pfizer's vaccine and compared them to those from health care workers who had a previous mild infection and a third group of patients who had serious cases of COVID-19. They found, "No neutralization escape could be feared concerning the two variants of concern [Alpha and Beta] in" those previously infected.[35]

30. That natural infection, unlike vaccine immunity, provides sterilizing immunity, is also reflected in the UK's official government COVID-19 data from the past 7 months while Delta was circulating which, as discussed above, reflects a probable

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[33] Brown CM, et al. *Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts*, MMWR Morb Mortal Wkly Rep (August 6, 2021) https://pubmed.ncbi.nlm.nih.gov/34351882/.

[34] Nguyen Chau, *Transmission of SARS-CoV-2 Delta variant among vaccinated healthcare workers, Vietnam*, Lancet (August 10, 2021) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3897733.

[35] Claudia Gonzalez, et al., *Live virus neutralisation testing in convalescent patients and subjects vaccinated against 19A, 20B, 20I/501Y.V1 and 20H/501Y.V2 isolates of SARS-CoV-2*, Emerg Microbes Infect (June 28, 2021) https://pubmed.ncbi.nlm.nih.gov/34176436/.

reinfection rate of 0.025%[36] (and a confirmed reinfection rate of 0.0026%) but a breakthrough rate for Delta infections of 23%.[37]

31. These data comport with the observation that given approximately 120.2 million individuals have been infected in the United States,[38] if reinfection occurred in only 1% of individuals, the United States would have observed 1.2 million second and third cases, with many coming to clinical attention and/or requiring hospitalization. In fact, no such large volume of recurrent cases has been observed in any part of the United States.[39] In the 21 months since the Covid-19 virus first appeared in the United States,

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[36] *See* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1012240/Weekly_Flu_and_COVID-19_report_w33.pdf at 17-18.

[37] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1014926/Technical_Briefing_22_21_09_02.pdf at 21. Meanwhile, the CDC – which is only reporting breakthrough cases which lead to hospitalization and death and whose "surveillance relies on passive and voluntary reporting" and acknowledges that "data are not complete or representative" and "are an undercount of all SARS-CoV-2 infections among fully vaccinated persons – has reported 14,115 breakthrough cases; https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html. Notably, Louisiana alone had counted 14,650 breakthrough infections as of August 25, 2021, https://www.politico.com/news/2021/08/25/cdc-pandemic-limited-data-breakthroughs-506823. Reflecting the sheer level of underreporting, Cornell University, despite a 95% vaccination rate for students and faculty, has more than five times the amount of confirmed positive cases during its first week of this academic year than it did during its first week of the 2020-21 academic year. https://www.thecollegefix.com/despite-95-vaccination-rate-cornell-today-has-five-times-more-covid-cases-than-it-did-this-time-last-year/. As of September 27, 2021, Harvard, despite boasting a rate of 96% faculty vaccinated and 95% students vaccinated, moved its business school remote due to "a 'steady rise' in breakthrough Covid-19 infection." https://www.bloomberg.com/news/articles/2021-09-27/harvard-moves-first-year-mba-students-online-amid-virus-outbreak?utm_source=facebook&cmpid=socialflow-facebook-business&utm_content=business&utm_campaign=socialflow-organic&utm_medium=social&fbclid=IwAR0SkJ2ifxRM1eJOOR-2pQw5NPaGFcB7lpirigx5aNag2k-bwSCyRq65dSo.

[38] *See* https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/burden.html.

[39] https://www.cdc.gov/coronavirus/2019-ncov/your-health/reinfection.html ("Cases of reinfection with COVID-19 have been reported, but remain rare" as of August 6, 2021).

doctors and scientists have not documented a single case of a naturally immune individual that was re-infected with and transmitted the virus to anyone.[40]

32. Taken together, the data reflects that while the vaccinated when exposed to the virus can silently spread the virus to others, the naturally immune will not silently spread the virus. And when the rare instances of reinfections occur, as noted, there has never been a documented case of transmission from a reinfection. This is despite a world-wide hunt for such a case.

33. The findings in the dozens of studies cited above are not surprising given that vaccines, by design, attempt to emulate the immunity created by a natural infection.[41] Nonetheless, vaccines never achieve the same level of protection afforded by natural infection from a virus.[42] They universally confer inferior immunity to having had the actual virus and even the best vaccines do not confer immunity to all recipients.[43] In those who do obtain some immunity from vaccination, the immunity created often wanes over time.[44]

34. A recent article aptly explained why infection-induced immunity to SARS-CoV-2 is much deeper and broader than vaccine immunity:

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[40] There is one case study published in Clinical Infections Diseases that told of a situation with a reinfection in one healthcare worker. Although the study states, "It seems likely that [the healthcare worker] played a role in the spread of this outbreak as she provides the only link between some of the patients," this is not definitive evidence of a proven case of reinfection and transmission. The study also states, "How transmission exactly occurred within this cluster of 4 individuals as well as its origin remain unclear." Additionally, were this a frequently occurring phenomenon, as stated above, there would be millions of cases of reinfection and evidence of transmission from same. *See* Selhorst P, et al., *Symptomatic SARS-CoV-2 reinfection of a health care worker in a Belgian nosocomial outbreak despite primary neutralizing antibody response*, Clin Infect Dis. (December 14, 2020) https://pubmed.ncbi.nlm.nih.gov/33315049/.

[41] *See* Plotkin's Vaccines, 7th Edition, at Section 2.

[42] *Id.*

[43] *Id.*

[44] *Id.*

> A natural infection induces hundreds upon hundreds of antibodies against all proteins of the virus, including the envelope, the membrane, the nucleocapsid, and the spike…Dozens upon dozens of these antibodies neutralize the virus when encountered again. Additionally, because of the immune system exposure to these numerous proteins (epitomes), our T cells mount a robust memory, as well. Our T cells are the 'marines' of the immune system and the first line of defense against pathogens. T cell memory to those infected with SARSCOV1 is at 17 years and running still….
>
> In vaccine-induced immunity…we mount an antibody response to only the spike and its constituent proteins … [and] this produces much fewer neutralizing antibodies, and as the virus preferentially mutates at the spike, these proteins are shaped differently and antibodies can no longer 'lock and key' bind to these new shapes.

35. There is also apparently a high likelihood that the current Covid-19 vaccines will soon be rendered ineffective with regard to certain variants and Pfizer's CEO has admitted as much, saying a vaccine-resistant variant will likely emerge.[45] This is also confirmed by researchers as Osaka University which found that "the SARS-CoV-2 Delta variant is poised to acquire complete resistance to wild-type spike vaccines."[46] Since vaccine-induced immunity does not prevent transmission or infection, this provides an

[45] https://www.insider.com/pfizer-ceo-vaccine-resistant-coronavius-variant-likely-2021-8.

[46] Yafei Liu, et al., *The SARS-CoV-2 Delta variant is poised to acquire complete resistance to wild-type spike vaccines*, medRxiv (August 23, 2021) https://www.biorxiv.org/content/10.1101/2021.08.22.457114v1.

opportunity for the virus to replicate in vaccinated individuals, driving the spread of vaccine-immunity-resistant variants. In contrast, naturally immune individuals have sterilizing immunity, and in almost every case, do not become infected with and spread the virus upon coming into contact with the virus. They do not act as reservoirs for viral replication and transmission of new variants. As a professor of viral immunology recently explained:

> Based on fundamental immunological principles, parenteral administration of these vaccines provides robust enough systemic antibody responses to allow these antibodies to spill over into the lower respiratory tract, which is a common point at which pathogens can enter systemic circulation due to the proximity of blood vessels to facilitate gas exchange. However, they do not provide adequate protection to the upper respiratory tract, like natural infection does, or like an intranasal or aerosolized vaccine likely would. As such, people whose immunity has been conferred by a vaccine only are often protected from the most severe forms of COVID-19 due to protection in the lower lungs, but they are also susceptible to proliferation of the virus in the upper airways, which causes them to shed equivalent quantities of SARS-CoV-2 as those who completely lack immunity. Dampened disease with equal shedding equals a phenotype that approaches that of a classic super-spreader.[47]

[47] https://onedrive.live.com/?authkey=%21ADfHk3IuaBrEH34&cid=914431B73799994E&id=914431B73799994E%2176735&parId=914431B73799994E%2173522&o=OneUp.

C. Serological Data

36. Reflecting the foregoing real-world data, the following studies further evidence the superiority of natural immunity:

a. Researchers at Rockefeller University concluded that memory B cells in those with prior infection "express increasingly broad and potent antibodies that are resistant to mutations found in variants of concern" and that "memory antibodies selected over time by natural infection have greater potency and breadth than antibodies elicited by vaccination."[48]

b. Researchers at the University of California concluded that "Natural infection induced expansion of larger CD8 T cell clones occupied distinct clusters, likely due to the recognition of a broader set of viral epitopes presented by the virus *not seen in the mRNA vaccine."*[49]

c. Researchers at the National Cancer Institute in Maryland and various Israeli institutions conducted a large-scale study of antibody titer decay following COVID-19 vaccine or SARS-CoV-2 infection. Aside from more robust T cell and memory B cell immunity, they found that antibodies wane slower among those who were previously infected. "In vaccinated subjects, antibody titers decreased by up to 40% each subsequent month while in convalescents they decreased by less than 5% per month."[50]

d. Researchers at Washington University School of Medicine found that, "People who recover [even] from mild COVID-19 have bone-marrow cells

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[48] Alice Cho, et al., *Anti- SARS-CoV-2 Receptor Binding Domain Antibody Evolution after mRNA Vaccination*, medRxiv (August 23, 2021) https://www.biorxiv.org/content/10.1101/2021.07.29.454333v1.

[49] Suhas Sureshchandra et a., *Single cell profiling of T and B cell repertoires following SARS-CoV-2 mRNA vaccine*, medRxiv (July 15, 2021) https://www.biorxiv.org/content/10.1101/2021.07.14.452381v1.

[50] Ariel Israel, et al., *Large-scale study of antibody titer decay following BNT162b2 mRNA vaccine or SARS-CoV-2 infection*, medRxiv (August 22, 2021) https://pubmed.ncbi.nlm.nih.gov/34462761/.

that can churn out antibodies for decades."[51] Thus, prior COVID-19 infection creates memory B cells that "patrol the blood for reinfection, while bone marrow plasma cells (BMPCs) hide away in bones, trickling out antibodies for decades" as needed.[52]

e. Researchers at various Korean institutions found that the T cells of the naturally immune had "stem-cell like" qualities and that long-term "SARS-CoV-2-specific T cell memory is successfully maintained regardless of the severity of COVID-19."[53]

f. Researchers at the La Jolla Institute for Immunology found that that the immune systems of those who recovered from COVID-19 had durable memories of the virus for the eight-month duration of the study.[54]

g. Researchers at Washington University School of Medicine found that "SARS-CoV-2 infection induces a robust antigen-specific, long-lived humoral immune response in humans."[55]

h. Researchers at Emory University and the Fred Hutchinson Cancer Research Center found that recovered COVID-19 patients mount broad, durable

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[51] Ewen Callaway, *Have COVID? You'll probably make antibodies for a lifetime*, Nature (August 22, 2021) https://pubmed.ncbi.nlm.nih.gov/34040250/.

[52] Jackson S. Turner, et al., *SARS-CoV-2 infection induces long-lived bone marrow plasma cells in humans*, Nature (May 24 2021) https://pubmed.ncbi.nlm.nih.gov/34030176/.

[53] Jung JH, et al., *SARS-CoV-2-specific T cell memory is sustained in COVID-19 convalescent patients for 10 months with successful development of stem cell-like memory T cells*, Nat Commun. (June 30, 2021) https://pubmed.ncbi.nlm.nih.gov/34193870/.

[54] Jennifer Dan, et al., *Immunological memory to SARS-CoV-2 assessed for up to 8 months after infection*, Science (February 5, 2021) https://pubmed.ncbi.nlm.nih.gov/33408181/. *See also* https://www.nih.gov/news-events/nih-research-matters/lasting-immunity-found-after-recovery-covid-19.

[55] Jackson S. Turner, et al., *SARS-CoV-2 infection induces long-lived bone marrow plasma cells in humans*, Nature (May 24, 2021) https://pubmed.ncbi.nlm.nih.gov/34030176/ .

immunity after infection, and that "[t]he durable antibody responses in the COVID-19 recovery period are further substantiated by the ongoing rise in both the spike and RBD memory B cell responses after over 3–5 months before entering a plateau phase over 6–8 months. Persistence of RBD memory B cells has been noted."[56]

i. Researchers at Aarhus University Hospital in Denmark studied the immune response following SARS-CoV-2 infections and found that the vast majority of recovered individuals had detectable, functional SARS-CoV2 spike-specific adaptive immune responses, despite diverse disease severities, making vaccination post-COVID-19 for any of them redundant.[57]

j. Researchers from the UK Coronavirus Immunology Consortium (UK-CIC), Public Health England and Manchester University NHS Foundation Trust found that every naturally immune person tested showed "robust T cell responses to SARS-CoV-2 virus peptides [six months after primary infection] in all participants" which included those with "asymptomatic or mild/moderate COVID-19 infection."[58]

k. Researchers from University of Minnesota Medical School found that "infection-induced primary MBCs [memory B cells] have better antigen-binding capacity and generate more plasmablasts and secondary MBCs of the classical and atypical subsets than vaccine-induced primary MBCs. Our results suggest that infection induced primary MBCs have undergone more

[56] Kristen w. Cohen, et al., *Longitudinal analysis shows durable and broad immune memory after sars-cov-2 infection with persisting antibody responses and memory b and t cells*, Cell Rep Med. (July 14, 2021) https://pubmed.ncbi.nlm.nih.gov/34250512/.

[57] Stine Sf Nielsen, Et Al. *Sars-Cov-2 Elicits Robust Adaptive Immune Responses Regardless Of Disease Severity*, Ebiomedicine (June 4, 2021) https://pubmed.ncbi.nlm.nih.gov/34098342/.

[58] https://www.uk-cic.org/news/cellular-immunity-sars-cov-2-found-six-months-non-hospitalised-individuals.

affinity maturation than vaccine-induced primary MBCs and produce more robust secondary responses."[59]

l. Researchers from NYU School of Medicine found that "In COVID-19 patients, immune responses were characterized by a highly augmented interferon response which was largely absent in vaccine recipients. Increased interferon signaling likely contributed to the observed dramatic upregulation of cytotoxic genes in the peripheral T cells and innate-like lymphocytes in patients but not in immunized subjects." They also found that "Analysis of B and T cell receptor repertoires revealed that while the majority of clonal B and T cells in COVID-19 patients were effector cells, in vaccine recipients, clonally expanded cells were primarily circulating memory cells."[60]

m. Researchers from the National Institutes of Health studied the likelihood of SARS-CoV-2 reinfection in people carrying antibodies against the virus, gathering data from more than 3.2 million people who had undergone SARS-CoV-2 antibody testing and found that those with SARS-CoV-2 antibodies became less likely to test positive for COVID-19 as time went on. The authors stated: "The data from this study suggest that people who have a positive result from a commercial antibody test appear to have substantial immunity to SARS-CoV-2, which means they may be at lower risk for future infection." [61]

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[59] Kathryn A. Pape, et al. *High affinity memory B cells induced by SARS-CoV-2 infection produce more plasmablasts and atypical memory B cells than those primed by mRNA vaccines*, Cell Reports (September 20, 2021) https://www.cell.com/action/showPdf?pii=S2211-1247%2821%2901287-0.

[60] Ivanova EN, et al. *Discrete immune response signature to SARS-CoV-2 mRNA vaccination versus infection*, medRxiv (April 23, 2021) https://pubmed.ncbi.nlm.nih.gov/33907755/.

[61] https://pubmed.ncbi.nlm.nih.gov/33625463/; https://www.nih.gov/news-events/nih-research-matters/sars-cov-2-antibodies-protect-reinfection.

n. Researchers from Swedish and UK institutions published a study which "shows that SARS-CoV-2 elicits broadly directed and functionally replete memory T cell responses, suggesting that natural exposure or infection may prevent recurrent episodes of severe COVID-19." This early finding of robust T cell memory has been supported by later studies as detailed above.[62]

D. Hybrid Immunity

37. Given the irrefutable evidence that natural immunity is superior to vaccine immunity by every measure, some have attempted to claim that natural immune individuals who were then vaccinated ("**hybrid immunity**") are more protected than those with just vaccine immunity. Even if correct, which is not supported by the balance of the data and studies, it is irrelevant. Natural immunity is already greater than 99% efficacious against COVID-19, regardless of variants, provides sterilizing immunity, and does not wane at nearly the rate vaccine-induced immunity wanes. Meaning, if Defendants are going to lift restrictions on the vaccinated, it is authoritarian and prejudicial to not lift the same restrictions on the naturally immune.

38. In any event, the largest available population-based study involving 2.5 million Israelis in a single centralized-medical database (representing one of the four national health care funds in Israel) found the naturally immune were 99.74% protected from reinfection while the naturally immune with subsequent vaccination were 99.86% protection from reinfection.[63] Putting aside that reinfections in both groups were mostly asymptomatic, this difference is negligible and has no clinical relevance. Numerous other large scale reliable studies have replicated these findings.

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[62] Takuya Sekine, Et Al. *Robust T Cell Immunity In Convalescent Individuals With Asymptomatic Or Mild Covid-19*, Cell (August 14, 2020) https://Pubmed.Ncbi.Nlm.Nih.Gov/32979941/.

[63] Sivan Gazit, et al., *Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections*, medRxiv (August 25, 2021) https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1.

39. On the other hand, according to data from the U.K., every 11 individuals with natural immunity that are vaccinated will have a clinically significant vaccine adverse event, with the most common adverse events being fever, fatigue, myalgia-arthralgia and lymphadenopathy.[64] Since vaccinating 833 naturally individuals is needed to prevent one case of *asymptomatic* reinfection (with the number being even higher for *symptomatic* reinfection), Defendants' policy will cause over 75 cases of clinically significant adverse events (NNT/NNH = 833/11).

40. Defendants also ignore data that natural immunity is stunted by subsequent vaccination. Notably, U.S. researchers from Case Western Reserve University School of Medicine, Ragon Institute of MGH, MIT and Harvard, and other institutes looked at humoral immunity from 2 weeks to 6 months post-vaccination in individuals both with and without pre-vaccination SARS-CoV-2 infection. The authors noted that, "[a]ntispike, anti-RBD and neutralization levels dropped more than 84% over 6 months' time in all [vaccinated] groups *irrespective of prior SARS-CoV-2 infection*." In a previously infected individual with natural immunity who does not get vaccinated, these levels do not drop off. In fact, these levels persist and even grow.[65] The fact that they drop following vaccination is an indication that vaccination is having an adverse effect on naturally induced immunity.[66] In other words, the normal, longstanding, robust

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[64] Rachael Kathleen Raw, Et Al. *Previous Covid-19 Infection, But Not Long-Covid, Is Associated With Increased Adverse Events Following Bnt162b2/Pfizer Vaccination,* The Journal Of Infection (May 29, 2021) https://Pubmed.Ncbi.Nlm.Nih.Gov/34062184/.

[65] Moriyama S., et al., *Temporal maturation of neutralizing antibodies in COVID-19 convalescent individuals improves potency and breadth to circulating SARS-CoV-2 variants,* Immunity (July 2, 2021) https://pubmed.ncbi.nlm.nih.gov/34246326/.

[66] Daniel Lozano-Ojalvo, Et Al., *Differential Effects Of The Second Sars-Cov-2 Mrna Vaccine Dose On T Cell Immunity In Naive And Covid-19 Recovered Individuals*, Cell Rep (August 3, 2021) https://Pubmed.Ncbi.Nlm.Nih.Gov/34390647/ (Researchers monitored a group of vaccinated people with and without prior infection and found that "in individuals with a pre-existing immunity against sars-cov-2, the second vaccine dose not only fail to boost humoral immunity but determines a contraction of the spike-

immunity which does not typically show significant waning and, in fact shows increasing potency over time, in those recovered is dropping 84% after vaccination.

41. In sum, the naturally immune already have sterilizing immunity and a negligible rate of reinfection, and no documented cases of subsequent transmission exist. This immunity alone is superior to vaccine immunity which is not sterilizing, creates asymptomatic carriers, has a high breakthrough rate and has many documented cases of subsequent transmission after breakthrough. It is simply irrational to apply limitations to the naturally immune but not to the vaccinated.

IV. COVID-19 VACCINES ARE NOT RISK-FREE AND THE RISK IS GREATER FOR THE PREVIOUSLY INFECTED

42. Studies have also demonstrated legitimate safety concerns regarding the current COVID-19 vaccines, and heightened safety concerns when vaccinating naturally immune individuals.

A. Vaccinating Naturally Immune Individuals Presents an Increased Risk

43. Studies have found that naturally immune individuals have significantly higher rates of adverse reactions when receiving the COVID-19 vaccine. For example, Raw, *et al.* reported that among 974 individuals vaccinated for COVID-19, the vaccinated

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specific t cell response." They also note that "the second vaccination does appears to exert a detrimental effect in the overall magnitude of the spike-specific humoral response in covid-19 recovered individuals."); *See Also* Jason Neidleman, Et Al., *Mrna Vaccine-Induced Sars-Cov-2-Specific T Cells Recognize B.1.1.7 And B.1.351 Variants But Differ In Longevity And Homing Properties Depending On Prior Infection Status* (May 12, 2021) https://www.biorxiv.org/content/10.1101/2021.05.12.443888v1 (Researchers assessed those vaccinated who were naïve to covid-19 and those vaccinated who had recovered (and did not assess those who recovered but were not vaccinated) concluded that, "[i]n infection-naïve individuals, the second dose boosted the quantity but not quality of the t cell response, while in convalescents the second dose helped neither. Spike-specific t cells from convalescent vaccinees differed strikingly from those of infection-naïve vaccinees, with phenotypic features suggesting superior long-term persistence and ability to home to the respiratory tract including the nasopharynx.").

COVID-19 recovered patients had higher rates of vaccine reactions. Mathioudakis, *et al*. found the same result in a study of 2,002 individuals vaccinated for COVID-19. Krammer et al. found the same result in a study of 231 volunteers vaccinated for COVID-19, concluding that, "Vaccine recipients with preexisting immunity experience systemic side effects with a significantly higher frequency than antibody naïve vaccines." In a paper published by Bruno, *et al*. the authors pose urgent questions on COVID-19 vaccine safety, highlighting the high number of reported serious adverse events and the shortcomings of the clinical trials, including the exclusion of those with prior SARS-CoV-2 infection.

B. The COVID-19 Vaccines Present Certain Risks for Everyone

44. There are also risks to receiving COVID-19 vaccines irrespective of prior infection. The primary system for tracking adverse events after vaccination in the United States is the Vaccine Adverse Events Reporting System ("**VAERS**"). A three-year federal government funded study by Harvard researchers tracking 715,000 patients found that "fewer than 1% of vaccine adverse events are reported."

45. Reports of serious adverse events from COVID-19 vaccines are similarly underreported to VAERS. For example, according to the CDC, "Anaphylaxis after COVID-19 vaccination is **rare** and occurred in approximately **2 to 5 people per million** vaccinated in the United States based on events reported to VAERS." This is in stark contrast to a recent study at Mass General Brigham that assessed anaphylaxis in a clinical setting after the administration of COVID-19 vaccines and found "severe reactions consistent with anaphylaxis occurred at a rate of **2.47 per 10,000 vaccinations**." This is equivalent to 50 to 120 times more cases than what VAERS and the CDC are reporting. And this is for a serious, potentially life-threatening, adverse event that occurs almost immediately after vaccination and which vaccine providers are repeatedly advised to watch for and report.

46. If anaphylaxis is being underreported, the level of underreporting for serious adverse events that do not occur immediately after vaccination or are not easily identified is likely far greater. For example, on June 23, 2021, the CDC reported the alarming numbers of reported myocarditis and pericarditis cases occurring after COVID-19 vaccination.[67] The long-term effects of myocarditis are not fully understood but can be very serious. Cases of thrombocytopenia have also occurred after COVID-19 vaccination, as well as serious and sometimes fatal blood clots.[68] These and numerous other serious adverse events are being recognized but the true rate of these serious adverse events is most certainly underreported.[69]

47. Even if the risks from the COVID-19 vaccines are truly small, there is no reason to expose someone to *any* risk when they are already immune to COVID-19.

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[67] https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-06/03-COVID-Shimabukuro-508.pdf at page 27.

[68] *See* https://www.fda.gov/news-events/press-announcements/joint-cdc-and-fda-statement-johnson-johnson-covid-19-vaccine.

[69] Research shows that the coronavirus spike protein from COVID-19 vaccines enters the bloodstream and can be found throughout the body in almost all vital organs. https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciab465/6279075. This would help explain the high rate of reported blood clots, heart disease, brain damage and reproductive issues. Dr. Byram Bridle, a viral immunologist and associate professor at the University of Guelph, Ontario, recently stated: "We made a big mistake. We didn't realize it until now…We thought the spike protein was a great target antigen, we never knew the spike protein itself was a toxin and was a pathogenic protein. So by vaccinating people we are inadvertently inoculating them with a toxin." https://omny.fm/shows/on-point-with-alex-pierson/new-peer-reviewed-study-on-covid-19-vaccines-sugge. Recent data from Japan – data not required by the U.S. – reflects that lipid nano particles from the vaccine encapsuling the spike protein mRNA are being deposited into vital organs after vaccination. Of concern are the data related to lipid nano particles depositing into the adrenal glands, bone marrow, liver, ovaries, brain, and spleen and increasing in quantity over time post-vaccination. https://www.icandecide.org/wp-content/uploads/2021/06/Translation-of-Japanese-data.pdf at 16-17.

V. THE MANDATE IMPLEMENTED BY DEFENDANT

48. On August 5, 2021, CDPH released its Health Care Worker Vaccine Requirement.[70] The stated purpose of the requirement is "to prevent [COVID-19's] further spread in hospitals, SNFs, and other health care settings" by requiring all health care workers to "have their first dose of a one-dose regimen or their second dose of a two-dose regimen [of COVID-19 vaccines] by September 30, 2021."[71]

49. The Frequently Asked Questions section of the Mandate address exemptions and does not provide for an exemption for naturally immune individuals. [72]

50. Plaintiff, along with other health care workers that have had the virus, will suffer great detriment if prevented from working at health care facilities. Plaintiff is frustrated and negatively impacted by the prospect of being forced to choose between an invasion of his bodily integrity or continuing his employment at UCI. Plaintiff merely wants the same right privileges afforded to others who are deemed immune through vaccination. Instead, he is being required, under threat of exclusion from UC and from his career, to violate his bodily integrity with an injection of a product that presents risks but no benefit to him or to others.

51. It is unscientific and lacks a rational basis, let alone a compelling reason, to allow vaccinated individuals to attend or work at UC in person when their immunity is less effective at preventing infection and spread of COVID-19 than those that have had COVID-19 while not allowing the naturally immune.

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[70] *See* https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx.

[71] *Id*.

[72] https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/FAQ-Health-Care-Worker-Vaccine-Requirement.aspx. (The Mandate allows those with a medical or religious exemption who have had COVID-19 within the last 90 days to be exempt from the testing otherwise required for those with an exemption to the vaccine mandate, however this is the only recognition of prior infection and natural immunity).

VI. DEFENDANT'S RESTRICTIONS VIOLATE PLAINTIFF'S CONSTITUTIONAL RIGHTS

A. Plaintiff's Right to Equal Protection of the Laws Has Been Violated

52. Plaintiff is naturally immune to SARS-CoV-2. Therefore, Plaintiff is at least as equally situated as those who are fully vaccinated with a COVID-19 vaccine, yet Defendant denies Plaintiff equal treatment and seek to burden Plaintiff with an unnecessary violation of bodily integrity to which Plaintiff does not consent in order to be allowed to continue to work at his healthcare facility.

B. Naturally Immune Individuals are Similarly Situated to Vaccinated Individuals

53. The Mandate's express purpose is to prevent the further spread of COVID-19.[73] Defendant seeks to achieve this by ensuring that only people who theoretically have immunity to the virus can work at health care facilities.[74] Both individuals with natural immunity, like Plaintiff, and individuals who are vaccinated are alike in that they have immunity to the virus that causes COVID-19. As the foregoing shows naturally immune individuals have at least as good, and in fact superior, immunity when compared to vaccinated individuals.

54. Nevertheless, the Mandate fails to treat these two groups of immune individuals similarly. Individuals who have vaccine created immunity will be permitted to work at health care facilities.[75] However, individuals who have natural immunity will not be allowed to work at health care facilities.[76]

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[73] *See* https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx.

[74] *Id.*

[75] *Id.*

[76] *Id.*

VII. PLAINTIFF IS SUFFERING AND WILL SUFFER IRREPARABLE HARM

55. Plaintiff will continue to suffer irreparable harm if the injunction requested is not granted. It has long been established that the loss of constitutional freedoms constitute irreparable harm. *Am. Trucking Ass'ns v. City of Los Angeles*, 559 F.3d 1046, 1059 (9th Cir. 2012); *Monterey Mech. Co. v. Wilson*, 125 F.3d 702, 715 (9th Cir. 1997).

56. Moreover, without an injunction, Plaintiff will suffer an impending loss of employment and of his professional reputation. Indeed, "the loss of one's job does not carry merely monetary consequences; it carries emotional damages and stress, which cannot be compensated by mere back payment of wages." *Nelson v. Nat'l Aeronautics and Space Admin.*, 530 F.3d 865, 877-78 (9th Cir. 2008), *rev'd on other grounds, Nat'l Aeronautics and Space Admin. v. Nelson*, 131 S. Ct. 746 (2011).

57. If Plaintiff is not permitted to work at UCI as a result of this Mandate, his practice and roles at UC will be drastically and adversely affected, including in the following ways:

a. He will not be able to attend in-person meetings with his team or with patients and families in the hospital and so his role as ethics committee chair and director of the ethics consult service will be impacted;
b. He will not be able to hold Monday and Tuesday afternoon Resident Clinic;
c. He will not be able to see his own patients from his practice as his faculty practice is located at the Department of Psychiatry clinic;
d. He will not be able to do his Resident in-person teaching;
e. He will not be able to do on-site ethics consultations in the hospital; and
f. He will not be able to teach the Ethics and Behavioral Science course for first-year students.

58. Treating naturally immune individuals differently from the fully vaccinated, when both have immunity, by demanding Plaintiff violate his right bodily integrity presents only a risk of harm and is unconstitutional.

COUNT I

For Declaratory and Injunctive Relief

(Fourteenth Amendment of the U.S. Constitution, Equal Protection)

59. Plaintiff re-alleges and incorporates by reference all of the allegations contained in all of the preceding paragraphs.

60. The Fourteenth Amendment, Section 1, to the United States Constitution provides:

> No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

61. Pursuant to the mandate, "[a]ll workers who provide services or work in [enumerated health care] facilities" are required receive a COVID-19 vaccination to be able to continue to work or provide those services. The natural immune are not exempted from the Mandate aside from the temporary natural immune exception.

62. The naturally immune have at least the same level of immunity to SARS-CoV-2 as do the fully vaccinated. Plaintiff has had a confirmed case of SARS-CoV-2 within. Plaintiff's immunity to SARS-CoV-2 is at least as robust and durable as that of a person fully vaccinated with a COVID-19 vaccine.

63. Defendant's mandate violates the Fourteenth Amendment to the U.S. Constitution, which includes clearly established fundamental rights and liberty interests of personal autonomy and bodily integrity, see, e.g., *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood v. Casey*, 505 U.S.

833 (1992); *Rochin v. California*, 342 U.S. 165 (1952); *Obergefell v. Hodges*, 576 U.S. 644 (2015); and the right to reject medical treatment, *Cruzan v. Director, Missouri Dep't Health*, 497 U.S. 261 (1990) and *Riggins v. Nevada*, 504 U.S. 127 (1992).

64. In modern jurisprudence, burdens upon fundamental rights require strict scrutiny. *Washington v. Glucksberg*, 521 U.S. 702 (1997) ("narrowly tailored to serve a compelling state interest").

65. As mandated vaccinations are a substantial burden, Defendant must prove narrow tailoring to a compelling interest that justifies mandatory vaccinations, not any more general interest. But while government may have a general interest in mitigating COVID, the following problems reveal no narrow tailoring to any compelling interest exists.

66. Critically, naturally acquired immunity from COVID is as robust as vaccine-acquired immunity, so there is no compelling interest (nor any rational basis) in vaccinating or requiring the vaccination of those who have already had COVID.

67. Further, given natural and vaccine immunity, California has COVID-19 herd immunity. The California Department of Public Health estimates that as of June 2021, 85.9% of adults age 18 and older in California have antibodies to SARS-CoV-2.[77] So Defendant has no compelling interest in mandating COVID vaccination.

68. The same evidence establishes that, assuming a compelling interest in preventing the spread of COVID-19, Defendant's Mandate is not narrowly tailored to such an interest since his immunity and that of the naturally immune is more protective than vaccine immunity.

[77] https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Sero-prevalence-COVID-19-Data.aspx. Notably, CDPH states that it is "no longer updating seroprevalence data." The percente of adults age 18 and older in California that have antibodies has most certainly increased – making it more than 85.9% – since July 9, 2021 both due to increased vaccination rates and natural infections.

69. Furthermore, even absent the fundamental rights at issue, the Mandate also violates the Fourteenth Amendment under modern rational basis scrutiny, since the Mandate is unreasonable and has no real or substantial relationship towards protecting the public health, particularly as applied to those with robust natural immunity. Defendant may not irrationally single out one class of individuals for discriminatory treatment. The Mandate irrationally singles out the convalescent and discriminates against them.

70. The Equal Protection Clause requires that persons who are similarly situated receive like treatment under the law.

71. The fully vaccinated and the convalescent are similarly situated and the Mandate affects them in an unequal manner, permitting admission to the fully vaccinated and denying admission to the convalescent.

72. The Mandate treats Plaintiff differently, and negatively, from other similarly situated persons based on the manner in which Plaintiff acquired immunity to SARS-CoV-2.

COUNT II

For Declaratory and Injunctive Relief

(Fourteenth Amendment of the U.S. Constitution, Substantive Due Process)

73. "The Fourteenth Amendment's due process clause 'provides heightened protection against government interference with certain fundamental rights and liberty interests.'" *Sanchez v. City of Fresno*, 914 F. Supp. 2d 1079, 1100-01 (E.D. Cal. 2012) (quoting *Glucksberg*, 521 U.S. 702, 720 (1997)). Plaintiff's constitutional right to bodily integrity is impinged by the Mandate.

74. It is well established that individuals have a fundamental liberty interest in and right to bodily integrity and informed consent. See *Benson v. Terhune*, 304 F.3d 874, 884 (9th Cir. 2002) ("The due process clause of the Fourteenth Amendment substantively protects a person's rights to be free from unjustified intrusions to the body"). "This notion

of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment." *Cruzan*, 497 U.S. 261, 277–78 (1990). See also Benson, 304 F.3d at 884 (a person has a right "to refuse unwanted medical treatment and to receive sufficient information to exercise these rights intelligently"). This means that the right to bodily integrity includes the concept that a "competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment." *Galvan v Duffie*, 807 Fed. Appx. 696, 697 (9th Cir 2020) (quoting *Cruzan*, 497 U.S. at 277–78).

75. The United States Constitution guarantees that state governments shall not "deprive any person of life, liberty, or property without due process of law," U.S. CONST. amend. XIV § 1, and "forbids the government to infringe certain 'fundamental' liberty interests at all, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest." *Reno v. Flores*, 507 U.S. 292, 301-302 (1993). Defendant lacks a compelling interest to impinge on Plaintiff's fundamental rights.

76. Plaintiff has constitutional and fundamental liberty interests in bodily integrity and informed consent, and the substantive due process rights to liberty and to life.

77. Plaintiff also has a constitutional and fundamental liberty interest in not being compelled to provide private medication information to the state, which is also being infringed by the mandates at issue.

78. Defendant cannot show that the Mandate serves a compelling state interest. While prior court decisions have found that a compelling state interest to control the spread of infection from person-to-person can trump certain constitutional rights in certain situations, see generally *Whitlow v. Cal. Dep't of Educ.*, 203 F. Supp. 3d 1079, 1089 (S.D. Cal. 2016), this interest is non-existent with respect to the COVID-19 vaccine

since this vaccine does not prevent vaccinated individuals from becoming infected and transmitting COVID-19.

79. Professor Sir Andrew Pollard, director of the Oxford Vaccine Group, has explained: "Herd immunity is not a possibility because [the Delta variant] still infects vaccinated individuals."[78] The vaccinated, when infected, can transmit the virus to others, and are more likely to do so because they have less symptoms and hence are more likely to interact with others not knowing they are contagious. On the other hand, those who have had the COVID-19 virus and recovered have not been shown to become re-infected and transmit the virus to others. Therefore, there is no compelling interest in requiring the COVID-19 vaccine.

80. Hence, excluding individuals from health care facilities and their careers as a means to compel such individuals to receive an injection of a COVID-19 vaccine does not pass strict scrutiny.

81. There is not even a rational basis to exclude the unvaccinated, recovered individuals from health care facilities since those vaccinated are at least as likely to spread COVID-19 and, in reality, are more likely.

82. Plaintiff hereby seeks declaratory and injunctive relief to prevent Defendant from depriving Plaintiff of the protections afforded to him under the Fourteenth Amendment of the U.S. Constitution. (U.S. Const., amend. XIV, § 1.) These Counts I and II are also brought pursuant to 42 U.S.C. §1983 and §1988(b), as well as for declaratory relief under 28 U.S.C. 2201.

83. Defendant's enforcement of the Mandate as announced will cause Plaintiff to suffer irreparable harm for which he has no adequate remedy at law. The Mandate

[78] https://twitter.com/Channel4News/status/1425086490002997248. Professor Pollard also stated that, "And what I suspect the virus will throw up next is a variant which is perhaps even better at transmitting in vaccinated populations. And so that's even **more of a reason not to be making a vaccine program around herd immunity**…" (emphasis added).

denies Plaintiff his rights under the Fourteenth Amendment and Plaintiff seeks a permanent injunction preventing Defendant from implementing and enforcing the Mandate against the naturally immune.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff requests the following relief:

1. Declare the Mandate unconstitutional as applied to the naturally immune;

2. Enjoin Defendant from enforcing the Mandate as against the naturally immune;

3. Grant Plaintiff his costs and attorneys' fees under 42 U.S.C. § 1988, and any other applicable authority; and

4. For such and other and further relief as this Court deems just and proper.

Dated: September 30, 2021

SIRI & GLIMSTAD LLP

By: /s/ Caroline Tucker
Aaron Siri (Pro Hac Vice to be filed)
Elizabeth Brehm (Pro Hac Vice to be filed)
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