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VIA FEDERAL EXPRESS & FAX

March 29, 2023

Governor Philip D. Murphy
Office of Governor
P.O. Box 001
Trenton, NJ 08625
Fax: 609-777-2922

James Demetriades
Penn Medicine, Princeton Health
One Plainsboro Road
Plainsboro, NJ 08536

Re: *COVID-19 Testing Requirement*

Dear Governor Murphy & President Demetriades:

On behalf of [redacted], a healthcare professional employed at Penn Medicine Princeton Health ("**Penn Medicine**"), we write regarding Executive Order ("**EO**") 283, requiring that healthcare workers be fully vaccinated against COVID-19, including a receipt of a booster vaccine. Pursuant to EO 283, healthcare workers who have an exemption to the COVID-19 vaccine mandate are required to test "weekly or twice weekly."[1]

On March 23, 2023, Amy Reigner, Chief Human Resources Officer for Penn Medicine, advised unvaccinated employees that they must continue to test once per week.[2] Ironically, the same letter informed that the testing venue site was being changed due to "declining cases in our community and lower demand for testing." The letter also directed unvaccinated employees to report or confirm the absence of common COVID-19 symptoms daily. Throughout this letter, the testing and reporting requirements are collectively called the "Requirements."

I. COVID-19 TESTING OF ASYMPTOMATIC INDIVIDUALS IS UNSCIENTIFIC

Human-to-human transmission of viruses can only take place if live virus is present and the viral load is sufficient. When virus carriers remain asymptomatic or mildly symptomatic, their viral loads are small. In fact, according to Dr. Anthony Fauci, "[e]ven if there is some asymptomatic transmission, in all the history of respiratory born viruses of any type, asymptomatic transmission has never been the driver of outbreaks.[3]

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[1] Governor Philip D. Murphy, Executive Order No. 283, Jan. 19, 2022, *available at* https://d31hzlhk6di2h5.cloudfront.net/20220119/3e/ed/04/e2/8502449ca1afe6e7bf7f6e2d/EO-283.pdf.

[2] Attachment A (March 3, 2023 Letter).

[3] Gianna Melillo, *HHS Secretary Azar Issues Updates on Novel Coronavirus,* AJMC, Jan. 28, 2020, *available at* https://www.ajmc.com/view/hhs-secretary-azar-issues-updates-on-novel-coronavirus

Furthermore, PCR tests are known to generate false positive results. For instance, in 2006, PCR testing results signaled a pertussis outbreak at Dartmouth-Hitchcock Medical Center when 146 individuals tested positive. However, a gold standard test later revealed that not even a single individual actually had pertussis.[4] At least two other pseudo-outbreaks implicated PCR tests, leading the US Centers for Disease Control and Prevention ("**CDC**") to proclaim that "overreliance on the results of PCR assays can lead to implementation of unnecessary and resource-intensive control measures." [5] Furthermore, "by screening asymptomatic patients without the history of a COVID-19 confirmed case contact, there is a high possibility of a test being inaccurate, giving rise to several consequences for the tested individual and the accuracy and acceptability of this testing assay as well."[6]

More recently, researchers found that 30 percent of positive COVID-19 tests were false positives.[7] In fact, in part because of the high probability of false positives, Norway discontinued testing based altogether early into the pandemic.[8] The New York Times has also reported that 90 percent of positive COVID tests are from people with clinically insignificant viral material.[9] Thus, data and science make it clear that forcing exempted employees to undergo weekly invasive PCR testing is unjustified.

II. THE REQUIREMENTS IGNORE THAT THE UNVACCINATED HAVE NATURAL IMMUNITY TO THE SARS-COV-2 VIRUS

A November 2022 study showed that 94 percent of the US population was estimated to have been infected by SARS-CoV-2 at least once.[10] The Johns Hopkins Coronavirus Resource

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[4] Gina Kolata, *Faith in Quick Test Leads to Epidemic That Wasn't*, New York Times, Jan. 22, 2007, *available at* https://www.nytimes.com/2007/01/22/health/22whoop html.

[5] *Outbreaks of Respiratory Illness Mistakenly Attributed to Pertussis --- New Hampshire, Massachusetts, and Tennessee, 2004—2006*, CDC, MMWR Weekly, Aug. 24, 2007 / 56(33);837-842, *available at* https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5633a1.htm

[6] Dimitra S. Mouliou, *The Deceptive COVID-19: Lessons from Common Molecular Diagnostics and a Novel Plan for the Prevention of the Next Pandemic*, *Diseases 2023*, Jan. 28, 2023, at *11*(1), 20, *available at* https://doi.org/10.3390/diseases11010020.

[7] Sin Hang Lee, *Testing for SARS-CoV-2 in cellular components by routine nested RT-PCR followed by DNA sequencing,* International Journal of Geriatrics and Rehabilitation, July 17, 2020 at 2(1):69-96, *available at* http://www.dnalymetest.com/images/IJGeriatRehabLee_on_SARSCoV2_test.pdf.

[8] David Nikel, *Norway Says Widespread Coronavirus Testing 'Unnecessary'*, Forbes, May 25, 2020, *available at* https://www.forbes.com/sites/davidnikel/2020/05/25/norway-says-widespread-coronavirus-testing-unnecessary/#54bad97177c5.

[9] Apoorva Mandavilli, *Your Coronavirus Test Is Positive. Maybe It Shouldn't Be.*, New York Times, July 3, 2021, *available at* https://www nytimes.com/2020/08/29/health/coronavirus-testing.html#click=https://t.co/uKyXUySVlM.

[10] Fayette Klaassen, *et al*., *Changes in population immunity against infection and severe disease from SARS-CoV-2 Omicron variants in the United States between December 2021 and November 2022*, medRxiv, Nov. 23, 2022 at 11.19.22282525, *available at* https://doi.org/10.1101/2022.11.19.22282525. *See also*, Dymphie Mioch, *et. al*., *SARS-CoV-2 antibodies persist up to 12 months after natural infection in healthy employees working in non-medical contact-intensive professions,* Int'l. J. Infectious Diseases, Jan. 2023 at 126:155-163, *available at* https://pubmed.ncbi nlm nih.gov/36436751/ (concluding that in this cohort, SARS-CoV-2 antibodies persisted for up to one year after initial seropositivity, suggesting long-term natural immunity.)

Center estimates that more than 65 million people have recovered from COVID-19 infections in the US.[11] It is impossible to conceive that any unvaccinated healthcare professional working in New Jersey has not been infected with the virus as least once, and exposure to the SARS-CoV-2 virus confers long-lasting and durable natural protection. In fact, research recently published in The Lancet reviewed 65 studies on natural immunity to find that the average effectiveness was at least 88 percent against hospitalization and death for all coronavirus variants ten months after infection.[12] Furthermore, a major study published in the Journal of Infectious Diseases in February of this year confirms that natural immunity from prior infection is superior to vaccinated immunity in nearly all aspects for most people.[13] This study, conducted by dozens of accredited medical researchers and funded by the CDC, found that natural immunity provided 76 percent protection against COVID-19-associated hospitalizations during the Omicron surge. Conversely, the Moderna or Pfizer vaccines provided just 39 percent protection for those without prior infection. The researchers also found that natural immunity lasted longer than mRNA vaccination plus boosters. During the Omicron surge, natural immunity protection against hospitalization was 74 percent for 150 or more days after infection. A primary vaccine series without prior infection provided just 39 percent protection beyond 149 days after the final vaccine. Three doses initially provided 81 percent protection but then faded to just 31 percent after 150 or more days following the last vaccine.[14] Finally, a Johns Hopkins study from February showed that 99 percent of unvaccinated people known to have COVID infections had robust "natural immunity" that did not diminish for at least 650 days.[15]

Critically, the CDC acknowledges the strong protection conferred by natural immunity. In January, the CDC released a report that analyzed COVID-19 cases in California and New York from May 30 to November 20 in 2021. The scientists compared the risk of new SARS-CoV-2 infection among four groups of people: (1) unvaccinated without a prior case of COVID-19; (2) vaccinated without prior COVID-19; (3) unvaccinated with prior COVID-19; and (4) vaccinated with prior COVID-19. The authors reported that after Delta became prevalent, natural immunity was more protective against infection than vaccination. During the Delta wave of COVID-19, the incidence of SARS-CoV-2 infection among those with vaccination and prior infection was 32.5-fold lower in California and 19.8-fold lower in New York, whereas rates among those vaccinated alone (without prior COVID-19) were only 6.2-fold lower in California and 4.5-fold lower in New York. The rates among those with natural immunity were 29.0-fold lower in California and 14.7-

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[11] Johns Hopkins University & Medicine Coronavirus Resource Center *available at* https://coronavirus.jhu.edu/map.html.

[12] Caroline Stein, *et. al.*, *Past SARS-CoV-2 infection protection against re-infection: a systematic review and meta-analysis*, The Lancet, March 11, 2023, Volume 401, Issue 10379, *available at* https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)02465-5/fulltext#%20.

[13] Catherine H Bozio, *et al., Protection From COVID-19 mRNA Vaccination and Prior SARS-CoV-2 Infection Against COVID-19–Associated Encounters in Adults During Delta and Omicron Predominance*, The J. of Infectious Diseases, Feb. 18, 2023, at jiad040, *available at* https://doi.org/10.1093/infdis/jiad040.

[14] *Id*.

[15] Jennifer L. Alejo, M.D., *et. al.*, *Prevalence and Durability of SARS-CoV-2 Antibodies Among Unvaccinated US Adults by History of COVID-19*, JAMA, Feb. 3, 2022, 327(11):1085–1087, *available at* https://jamanetwork.com/journals/jama/fullarticle/2788894.

fold lower in New York. The authors note that hospitalization rates followed a similar pattern.[16] Forcing unvaccinated employees with natural immunity to undergo invasive testing and intrusive reporting is punitive and serves no purpose other than punishing them.

III. THE REQUIREMENTS IGNORE THAT THOSE WHO HAVE RECEIVED A COVID-19 VACCINE AND BOOSTER CAN STILL CONTRACT AND TRANSMIT SARS-COV-2

On August 5, 2021, the Director of the CDC, Dr. Rochelle Walensky, stated on CNN that "what [the COVID-19 vaccines] can't do anymore is prevent transmission."[17] After this admission, Wolf Blitzer asks Dr. Walensky if "you get COVID, you're fully vaccinated, but you are totally asymptomatic, you can still pass on the virus to someone else, is that right?" and Dr. Walensky answers, "that is exactly right."[18] On June 23, 2022, the CDC again reinforced that the COVID-19 vaccines do not prevent breakthrough infections, which can still occur following primary series vaccines and a booster dose and even when vaccination rates are high, and that "[p]eople who get vaccine breakthrough infections can spread COVID-19 to other people."[19] As a result of the vaccines' failures and the acknowledgment of natural immunity, on August 11, 2022 the CDC updated its guidance for the prevention of COVID-19,[20] which in particular:

- Recognized the immunity and protection provided to those who have previously recovered from a COVID-19 infection: "The risk for medically significant illness increases with age, disability status, and underlying medical conditions but is considerably reduced by immunity derived from vaccination, previous infection, or both, as well as timely access to effective biomedical prevention measures and treatments."

- Confirmed that "[h]igh levels of immunity and availability of effective COVID-19 prevention and management tools have reduced the risk for medically significant illness and death."

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[16] *See also*, Noah Kojima, *et al., Protective immunity after recovery from SARS-CoV-2 infection*, The Lancet, Nov. 8, 2021, Volume 22, Issue 1 at 12-14, *available at* https://doi.org/10.1016/S1473-3099(21)00676-9 (reviewing large studies conducted throughout the world and finding "well conducted biological studies showing protective immunity after infection. Furthermore, multiple epidemiological and clinical studies, including studies during the recent period of predominantly delta (B.1.617.2) variant transmission, found that the risk of repeat SARS-CoV-2 infection decreased by 80·5–100% among those who had had COVID-19 previously.").

[17] The Situation Room (@CNNSitRoom), Twitter (Aug. 5, 2021), *available at* https://twitter.com/CNNSitRoom/status/1423422301882748929. *See also*, Madeline Holcombe, *et. al.*, *Fully vaccinated people who get a Covid-19 breakthrough infection can transmit the virus, CDC chief says*, CNN health, Aug. 6, 2021, *available at* https://www.cnn.com/2021/08/05/health/us-coronavirus-thursday/index html.

[18] *Id*.

[19] Centers for Disease Control and Prevention, *Monitoring COVID-19 Cases, Hospitalizations, and Deaths by Vaccination Status*, Mar. 21, 2023, *available at* https://www.cdc.gov/coronavirus/2019-ncov/vaccines/effectiveness/why-measure-effectiveness/breakthrough-cases.html.

[20] Greta M. Massetti, Ph.D., *et. al.*, *Summary of Guidance for Minimizing the Impact of COVID-19 on Individual Persons, Communities, and Health Care Systems — United States*, August 2022, MMWR, Aug. 19, 2022, *available at* https://www.cdc.gov/mmwr/volumes/71/wr/mm7133e1.htm.

- No longer differentiated based on a person's vaccination status because "breakthrough infections occur, though they are generally mild, and persons who have had COVID-19 but are not vaccinated have some degree of protection against severe illness from their previous infection."

- Confirmed that "receipt of a primary series alone, in the absence of being up to date with vaccination through receipt of all recommended booster doses, provides minimal protection against infection and transmission."

Furthermore, Anthony Fauci recently stated that "[a]fter more than 60 years of experience with influenza vaccines, very little improvement in vaccine prevention of infection has been noted. . . our best approved influenza vaccines would be **inadequate for licensure** for most other vaccine-preventable diseases. . . . However, as variant SARS-CoV-2 strains have emerged, deficiencies in these vaccines reminiscent of influenza vaccines have become apparent."[21] Finally, a peer-reviewed publication released on Sept 21, 2022 found that "[a] worldwide Bayesian causal impact analysis suggests that COVID-19 gene therapy (mRNA vaccine) causes more COVID-19 cases per million and more non-Covid deaths per million than are associated with COVID-19. . . . An abundance of studies has shown that the mRNA vaccines are neither safe nor effective, but outright dangerous."[22] For these reasons, it is clear that the Requirements directly conflict with CDC guidance and current knowledge about SARS-CoV-2.

IV. REQUIRING HEALTHCARE WORKERS WITH MEDICAL OR RELIGIOUS EXEMPTIONS TO ADHERE TO THE REQUIREMENTS CONSTITUTES DISCRIMINATION

The Civil Rights Act of 1964[23] ("**Title VII**") states in relevant part:

> It shall be an unlawful employment practice for an employer –
>
> (1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin; or
>
> (2) to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise

[21] David M. Morens, *et. al., Rethinking next-generation vaccines for coronaviruses*, *influenzaviruses, and other respiratory viruses*, Cell Host & Microbe, Jan. 11, 2023, Volume 31, Issue 1 at P146-157 *available at* https://www.cell.com/cell-host-microbe/fulltext/S1931-3128(22)00572-8#%20.

[22] Conny Turni, *et. al., COVID-19 vaccines – An Australian Review,* Journal of Clinical & Experimental Immunology, Sept. 21, 2022 available at https://www.opastpublishers.com/open-access-articles/covid19-vaccinesan-australian-review.pdf.

[23] 42 U.S.C. § 2000e-2 *et seq*.

> adversely affect his status as an employee, because of such as individual's race, color, religion, sex, or national origin.

New Jersey healthcare workers who cannot receive COVID-19 vaccination because of sincerely held religious convictions continue to experience disparate "outing" treatment by the state of New Jersey with physically invasive and uncomfortable testing that is scientifically unjustified. The state is fostering a pervasive environment of religious discrimination in violation of Title VII according to disparate impact and disparate treatment theories of discrimination. Furthermore, the testing requirement is punitive, amounts to retaliation, and creates a hostile work environment for religious employees.

Likewise, New Jersey's healthcare workers who cannot receive a COVID-19 vaccine for medical reasons are protected by the Americans with Disabilities Act 1990[24] (the "**ADA**"). Like Title VII, the ADA protects employees against discrimination, retaliation, and hostile work environments. The Requirements are purely punitive for unvaccinated employees and are not reasonably calculated toward preventing the spread of the SARS-CoV-2 virus.

Furthermore, Penn Medicine's enforcement of the Requirements for the unvaccinated constitutes disability-based discrimination by treating unvaccinated employees as if they are perpetually infected with COVID-19.[25] The ADA prohibits employers from discriminating against employees with perceived disabilities.[26] The disparate treatment of these through asymmetrical policies demonstrates that Penn Medicine clearly regards its unvaccinated employees as having "a physical or mental impairment"[27] that substantially limits their ability to work. By requiring unvaccinated employees to undergo invasive weekly testing and intrusive reporting, it is clearly regarding them as perpetually infected with COVID-19 and has perceived them as disabled under the ADA. Disparate treatment of an employee based on a perceived medical condition constitutes unlawful discrimination unless the employer can demonstrate through objective evidence that the individual poses a "direct threat" to the workplace such that the person poses a significant risk to the health or safety of others that cannot be eliminated or reduced by reasonable accommodation. Penn Medicine cannot show that unvaccinated employees are a direct threat to the workforce. The ADA defines a "direct threat" as:

> a significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation. The determination that an individual poses a "direct threat" shall be based on an individualized

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[24] 42 U.S.C § 12101 *et seq.*

[25] *See* 29 C.F.R. 1630.2(g)(1)(iii) (defining disability to include "[b]eing regarded as having such an impairment" and being "subjected to an action prohibited by the ADA as amended because of an actual or perceived impairment that is not 'transitory and minor'").

[26] *See* 42 U.S.C. 12102(1) (Disability is defined as "being regarded as having such an impairment [that substantially limits one or more major life activities])."

[27] *See* 29 C.F.R. 1630.2(h) (defining "physical or mental impairment" as "(1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as [the]. . . respiratory . . . [and] immune [systems]. . . ").

> assessment of the individual's present ability to safely perform the essential functions of the job. This assessment shall be based on a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence. In determining whether an individual would pose a direct threat, the factors to be considered include:
> (1) The duration of the risk;
> (2) The nature and severity of the potential harm;
> (3) The likelihood that the potential harm will occur; and
> (4) The imminence of the potential harm.[28]

Further:

> It is unlawful for a covered entity to use standards, criteria, or methods of administration, which are not job-related and consistent with business necessity, and: (a) That have the effect of discriminating on the basis of disability; or (b) That perpetuate the discrimination of others who are subject to common administrative control.[29]

Penn Medicine's uniform treatment of all unvaccinated religious employees and those with medical conditions that prevent vaccination as a direct threat *per se* fail to provide the required individualized assessment of the employee's situation. Moreover, the Requirements are irrational and contrary to "reasonable medical judgment that relies on the **most current medical knowledge** and/or on the **best available objective evidence**."[30]

We note that as early as July 2021, Dr. Walensky admitted that the vaccinated had similarly high viral loads of SARS-CoV-2 as the unvaccinated and thus could still contract and spread the Delta variant.[31] Furthermore, a study put forth by the CDC and the Wisconsin Department of Health Services in August 2021 affirmed this statement, indicating that the vaccinated had a 5 percent higher viral load than the unvaccinated and were not only just as likely to transmit the virus as the unvaccinated but posed a greater contagion risk due to the increased likelihood of asymptomatic infection.[32] The Governor's Executive Order has long been obsolete and ignores currently available science. It is clear that the Requirements serve no other purpose other than to punish those who did not receive the vaccines.

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[28] 29 C.F.R. §1630.2(r) (emphasis added).

[29] 29 C.F.R. §1630.7 (emphasis added).

[30] 29 C.F.R. §1630.2(r) (emphasis added).

[31] Centers for Disease Control and Prevention, *Statement from CDC Director Rochelle P. Walensky, MD, MPH on Today's MMWR*, CDC News Room, July 30, 2021, *available at* https://www.cdc.gov/media/releases/2021/s0730-mmwr-covid-19.html. ("Today, some of those data were published in CDC's Morbidity and Mortality Weekly Report (MMWR), demonstrating that Delta infection resulted in similarly high SARS-CoV-2 viral loads in vaccinated and unvaccinated people. High viral loads suggest an increased risk of transmission and raised concern that, unlike with other variants, vaccinated people infected with Delta can transmit the virus.").

[32] *See* Kasen K. Riemersma, *et. al., Shedding of Infectious SARS-CoV-2 Despite Vaccination,* medRxiv, Aug. 24, 2021, *available at* https://www.medrxiv.org/content/10.1101/2021.07.31.21261387v4.

V. CONCLUSION

For the foregoing reasons, Penn Medicine's unvaccinated employees can demonstrate that Penn Medicine discriminated against them on the basis of their religious beliefs and medical conditions. Further, these employees possess meritorious claims that Penn Medicine regarded them as disabled. Title VII and the ADA permit class action-based litigation, and these statutes provide for various damages, including attorney's fees, compensatory damages for emotional distress, medical issues, and other expenses resulting from discriminatory actions. Significantly, punitive damages are available where the discrimination is willful, as the record supports.

Unvaccinated healthcare workers in New Jersey have suffered and continue to suffer significant physical and emotional harm. These employees are entitled to a work environment free from discrimination, hostility, and retaliation.

Nothing stated or not stated here shall constitute a waiver of any claims, rights, causes of action, defenses, positions, or remedies, and each is expressly reserved.

The Firm's contact person for this matter is Allison R. Lucas, reached at alucas@sirillp.com. We request a response by **5 PM EST** on **Friday, April 7, 2023.**

Sincerely,

Debra Gambella

Debra Gambella, Esq.
Allison R. Lucas, Esq.

Enclosure

Penn Medicine
Princeton Health

March 3, 2023

Dear Penn Medicine Princeton Health Team Member,

I am writing to update you on significant changes in the testing procedures and requirements for Princeton Health employees such as yourself who are exempt from receiving the COVID-19 vaccine.

Effective immediately, vaccine-exempt employees who are not experiencing symptoms must be tested for COVID-19 **once per week**. As you are aware, the requirement had been twice a week, but we are now able to reduce the frequency by half.

In addition, the testing venue will change. The drive-through, COVID-19 testing hut on the Princeton Medical Center (PMC) campus is scheduled to cease operations on Wednesday, March 15, due to declining cases in our community and lower demand for testing.

Beginning Tuesday, March 14, employee testing will be available by appointment only in the PMC Laboratory Patient Service Center, located in the Medical Arts Pavilion, 5 Plainsboro Road, Suite 160, Plainsboro, NJ 08536. (See attached floor plan.)

Testing appointments for vaccine-exempt, asymptomatic employees will be available from Tuesday through Friday, 11 am to 5 pm. Appointments must be scheduled through PennOpen Pass.

You should continue using PennOpen Pass every day to report (or confirm the absence of) common COVID-19 symptoms or exposures to COVID-positive individuals.

Your Green Pass for the day will include a button with the message “Want COVID-19 testing?”

Click that link and follow the prompts to schedule your routine, weekly tests, just as you do today.

Tests scheduled during work hours must be approved by your supervisor in advance. As has been our practice, testing outside of work hours will be paid according to the attached guidelines.

NOTE: The process above applies only to your routine testing. If you are symptomatic or you need follow-up testing after receiving a Red Pass, you will receive separate instructions.

Please contact your supervisor or Human Resources Business Partner with questions.

Thank you in advance for your continued cooperation and, as always, thank you for all you do for our patients and the greater community.

Amy Reigner

Amy Reigner
Chief Human Resources Officer
Penn Medicine Princeton Health